



HEALTHCARE WRITING

A Practical Guide
to Professional
Success

Michael Arntfield
and James Johnston

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Preface

When we were approached a few years back about putting together a university course called “Writing for Professional Success in Nursing,” we didn’t imagine having quite the difficulty we had finding a textbook suitable to our needs and to those of our students. So we took it upon ourselves to write one, and this is the result. *Healthcare Writing: A Practical Guide to Professional Success* aims to address a general need for a broadly informed, practical writing handbook aimed almost equally toward two distinct audiences. The first is comprised of university and college students in healthcare-related programs, for whom we hope this book might prove either the primary text in a writing- or communications-focused course or an invaluable supplementary resource in other discipline-specific courses with written components.

The second audience consists of existing healthcare practitioners who may be seeking a portable, readable writing reference and guide geared towards helping them brush up on and improve their skills in the sorts of contemporary communication tasks they might encounter on any given day. Our goal is to offer in this book something that combines a focus on the practical application of communication strategies and models to recognizable healthcare scenarios, contexts, and genres with a corollary focus on fostering the basic writing skills integral both to student readers’ progression through their programs and to healthcare professionals’ success in their chosen fields.

In recent years, there has been an important, necessary shift in the study and practice of healthcare communication to a more transdisciplinary model. Such a move is characterized by the increasing awareness and incorporation of elements drawn from other writing and communication fields: professional and intercultural communication principles, narrative theory, and academic argumentation. This book takes a similarly broadly informed approach to defining, describing, and discussing concepts and themes pertinent to the understanding and practice of writing for healthcare providers, current and future. Our approach to this material is influenced by the fact that we come to our interest in healthcare writing by way of combined experience with and expertise in other writing and communication topics: forensic writing, rhetorical theory, business communication, media writing, and narratology. Throughout this text, we have highlighted terms drawn from these same cognate fields in order to refer the reader to a detailed glossary found at the end, and where these terms in the context of healthcare writing are further explicated. Readers, whether students or current practitioners, may find the glossary to be a useful study guide and field manual all its own.

The first two-thirds of this book map out a focused progression of writing models and strategies applicable to a range of real-world healthcare communication contexts. Devoted to “Everyday Writing in Healthcare,” the first section begins by defining and modelling three basic and important forms of written communication common across multiple healthcare contexts: notes, charts, and reports. In the second chapter, one guided by current understanding of effective professional communication, the framework of “Everyday Writing” is applied to a discussion of some non-patient-focused forms of interpersonal communication most germane to healthcare—letters, electronic correspondence, and presentations. The second large section of the book, “Narratives in Healthcare,” progresses logically out of the discussion of interpersonal writing. It offers in part something of a primer on the principles underpinning the study and practice of narrative medicine, a very important focus of contemporary healthcare communication but one that has to this point been largely neglected by existing health-care-writing texts. An introduction

to, and discussion of, narrative medicine comprises the first portion of the initial chapter in this section, while the latter portion draws upon material from the previous section's discussion of charts, tracing key concerns of narrative medicine through the particular practice of parallel charting, then examining how parallel charting leads into portfolio writing. From there, the second chapter of the "Narratives in Healthcare" section focuses specifically on another contemporary model of health narrative, the pathography, and goes on to address and explore the important ways in which the communication of healthcare narratives now increasingly and necessarily intersects with modes of and approaches to new media writing, specifically medical blogging and healthcare wikis.

The third and final part of the book focuses on "Fundamentals of Successful Healthcare Writing" and provides a thorough discussion of the basic material of writing instruction that is essential to, and expected in, any introductory text. The long first chapter of this section ([chapter 6](#)) concerns basics of grammar, punctuation, and style, with the discussion supplemented by a series of self-check quiz exercises at the end of the book designed to provide opportunity to practise and consolidate the material. In terms of scope and approach, the grammatical content here is in line with what we cover (and how we cover it) when we teach writing to our nursing students at Western. Our aim is for the material on grammar, punctuation, and style to be able to stand on its own, coherent and cohesive when considered in isolation from the previous two sections of the book. At the same time, when the book is considered as a whole, we mean that material also to follow from and look back usefully to the sections that precede it, as well as to anticipate the chapters that come after. By way of conclusion, those final two chapters both turn to "Healthcare Research and Academic Writing." Their main focus is on helping undergraduate students in healthcare fields develop strategies for thinking about and approaching the writing of academic documents, as well as compiling, organizing, and presenting research materials effectively in essays and reports.

Each chapter throughout concludes in the same way, with a summary of key points of content and some suggestions for self-check activities and discussion exercises that might assist the reader with comprehending and consolidating the chapter's material. In the end, our sincere hope is that students and healthcare professionals alike will see in this book a valuable and ready opportunity not only to develop and refine some of the key context-specific communication skills they might require to (continue to) succeed within their particular fields but also to help them grow into more effective, aware, and successful writers and communicators generally.

Acknowledgements

As our preface notes, this book and the existing void it fills with respect to healthcare writing and communication came to fruition in large part through pedagogical necessity. It also came about through the invaluable contributions made by those healthcare professionals who prompted us to write it. When we were tasked with building a university-level healthcare-writing course from the ground up, we found a dearth of options when searching for suitable textbooks. This lack of viable options led us to consider and implement a few different selections over the first years of the course; beyond the surface, however, all of them were really just conventional grammar and style guides dressed up to look like healthcare-specific texts. In the end, they lacked any substantive real-world context for students entering health-sciences programs such as nursing, those matriculating in medical school, or new graduates preparing for careers in healthcare promotion.

Certainly, there were a number of very earnest and scholarly works that explored in great analytical detail the theory of medical writing. While these titles are well suited for any of the increasingly popular graduate-level programs in health communication or even healthcare business administration, they were found to exceed the scope and key learning objectives of undergraduate courses designed to prepare students for the fundamentals of writing and communicating in the field with clarity, confidence, and accountability. Moreover, they had little to no applicability with respect to existing healthcare practitioners seeking a general reference guide or manual of style.

Part of the reason why there were, until now, so few options in terms of adequate and relevant textbooks is that healthcare writing is still a field that might be described as being in its adolescence. As outlined in this book, it has only been in the last twenty years or so—in comparison to centuries' worth of scholarship in other forms of writing and composition—that writing in healthcare has been deemed a learning priority, a required skill set, or an area of both discernible scholarship and professional development. Thus, this book is at the forefront of a burgeoning area of future academic and professional growth and training. That said, our combined backgrounds as both authors and professors encompass legal and professional communication, forensic writing and linguistics, and English literature in the more traditional sense. While some of these areas of expertise blend nicely with healthcare writing, and while healthcare writing is generally a discipline-specific and more rigorous and dynamic extension of other forms of professional and institutional writing, we are not, at the end of the day, healthcare providers.

It is for this very reason that this book is different from its antecedents, and why we also owe a debt of gratitude to those healthcare providers, practitioners, and clinical professionals who assisted with its creation. In recognizing the need for this book and its long-term value beyond the lecture hall and into the professional world, where there has also been a demand for a relevant and accessible field manual, a great number of healthcare experts took the time to peer review and provide feedback on everything found in this book. The chapter topics and subtopics, as well as all the sample texts and interactive exercises found in this book, have been vetted by some of the most experienced practitioners and specialists we could find, all of whom provided honest and frank feedback about what this book should and should not include in terms of teaching (or reteaching) communication fundamentals in healthcare. These outside experts we consulted range from physicians with small family practices to intensivists and critical-care

specialists working in major, world-recognized hospitals, as well as nurses and nurse managers, respirologists, radiologists, psychiatrists, coroners, paramedics, x-ray and ultrasound technicians, obstetricians, and clinical professors of medicine, health sciences, and nursing. To obtain as full a picture as possible, and to be able to relate the contents of this book to as many students and practitioners as reasonably practical, we also consulted existing professionals practising in extended, holistic, and even alternative forms of healthcare, including massage therapists, podiatrists, reflexologists, acupuncturists, and midwives.

In total, over thirty practising experts with a combined five hundred years' experience assisted tremendously with the creation of this book, and it is for these men and women and those students who will ultimately join them in the honourable practice of healthcare that this book is written. We are grateful to those who took the time to read our often lengthy emails and manuscripts, and who were in turn able continually to offer suggestions on how to improve this book. We are especially thankful to those practitioners who were able to provide anonymized field samples of text reflecting real-life scenarios and case studies. It is these samples that offer the study exercises and examples found here an expanded degree of realism and practicality that we trust students and even currently practising clinicians will find invaluable.

It would be remiss of us not to thank Broadview Press as well, particularly Marjorie Mather and Tara Trueman, for helping us see this book through from idea to publication. And lastly, we are grateful indeed to our undergraduate healthcare writing students who, through a heuristic process of trial-and-error, helped us determine what exactly this project should look like in terms of style and content, how the chapters should unfold in terms of logical order, and how generally to shape a textbook that can keep students engaged. This last consideration of engagement includes understanding how to help them project the long-term applications of what they read and learn. It is also the case that writing [chapters 7 and 8](#) would simply not have been possible without the contribution of helpful samples from some very earnest and capable student writers. For their generosity and willingness to assist so many potential future colleagues, we owe a debt of gratitude to those writers, namely Alexa Buxton and Stephanie Liokosis.

In summary, while we are listed as the authors, there have been countless contributors to and advisors on this book. While there are simply too many contributors and advisors to thank or otherwise acknowledge by name—and as a testament to their character, most actually asked to *not* be named—you know who you are, and your commitment to success in healthcare will carry on with this book.

With thanks,

Michael Arntfield, PhD

James Johnston, PhD

PART I

Everyday Writing in Healthcare

In-Patient Writing: Notes, Charts, and Reports

1

This chapter addresses some of the professional concerns and key competencies with respect to technical and professional writing among front-line healthcare workers. More specifically, it provides an overview of many of the more common types of writing that those employed in hospitals or any environment providing emergency or primary care can expect to compose with regularity.

English composition and the practice of medicine, especially front-line medicine, would seem—at least based on what was once deemed conventional thinking—to be diametrically opposed in terms of professional competencies. It certainly goes without saying that those drawn to careers in primary and even secondary healthcare, and the health sciences generally, are in most cases not enthusiastic about matriculating in courses or training modules that involve practical writing, much less essay and scholarly writing. The type of hands-on work found in clinical settings, coupled with the stereotypically scientific background of both healthcare students and practitioners, also seems to be at odds with the idea of rigorous paperwork; the documentary requirements of healthcare were thus historically seen with a certain degree of disdain—or were ignored entirely. That was then; this is now.

The previously prevailing culture surrounding writing and reporting in healthcare is now understood to be outmoded. It was a paradigm that survived as long as it did in part because it was rooted in the once popular idea that healthcare workers are generally split into one of two categories: the operational/clinical category and the administrative/managerial category. It was often the theory that only the latter group—administrators—required ongoing training with respect to official communication practices, whether written or verbal. In reality, this supposition is little more than a myth reflecting a bygone era. The truth is that as a result of current adequacy standards across myriad healthcare fields, coupled with the rigours of the current **knowledge-based economy**, where information prevails as the chief asset of any professional organization, communication—especially written communication—has become the core competency that transcends all healthcare professions. Written communication is now inarguably a baseline skill required by not only healthcare administrators, but also all front-line and clinical staff, regardless of one's specialty or the nature of her assignment in the field, and whether as a student or seasoned practitioner.

Without being overly restrictive, written communication in healthcare can generally be divided into three main categories: communication in the context of patient care, communication in the context of research medicine and professional development, and what might be called institutional communication. In this sense, institutional describes the day-to-day clinical and administrative communication practices that connect healthcare professionals with the organizational structure of their hospitals, clinics, and even the legislative bodies that oversee and regulate healthcare operations. While all of these categories require effective writing skills, it is this last category—institutional communication—that is primarily addressed in the first part of this book. It is also the category that most likely requires the greatest command of written English.

Institutional communication is also the one area of professional and procedural writing in healthcare that lacks standardization and any substantive mandated training. Unlike in professions such as law, finance, and education, writing in the medical and healthcare fields—at least with respect to front-line clinical operations—is a competency that has historically been learned heuristically, that is, through trial-and-error and on the fly, and without any specific instruction or mentorship. Traditionally speaking, standardized forms and ledgers that existed solely in hard copy helped to mitigate some of these shortcomings; however, the digitization of health records and, by extension, all forms of **institutional writing**, has left many practitioners realizing that in the information age, being able to effectively and professionally author notes, reports, and records without the use of a preprinted template is more difficult than expected. Many clinicians and other healthcare professionals practising, apprenticing, or otherwise employed or studying in any number of subfields have remarked—usually after a major setback, or in confronting a challenging situation for which they found themselves ill-prepared—that effective technical writing and institutional communication is as key a competency in terms of risk management as any of their clinical skills. Simply put, poor writing, reporting, and note taking have been known to cost jobs and even lives. They also consistently cost hospitals money through both litigation and unnecessary duplication.

Part of the challenge in teaching healthcare professionals how to acquire and subsequently apply institutional writing skills rests in the fact that few professors or teachers of English and professional communication fully understand the dynamic, unpredictable nature—and evolving challenges—of the clinical healthcare setting. Conversely, the university and college curricula required to prepare one for a career in medicine at any level—physician, nurse, technician, or other type of clinical practitioner—seldom make space for advanced course work in communications. Seldom have they sought, historically, to assist students in developing the nuances of written communication for professional audiences *before* they make their forays into the care-delivery environment where the stakes are elevated. Until recently, many courses serving as required electives in healthcare programs tended to prioritize alternative types of writing, including narration (anecdotal writing) that, while certainly applicable to clinical writing as explained in **Part II** of this textbook, require a mastery—or at the very least a convincing command—of everyday institutional writing. It is this everyday procedural prose that serves as the basis for other forms of creative or cathartic narratives that can then be developed afterward.

Institutional writing of the type found in or commonly associated with healthcare settings serves as a reminder that written clinical communication needs to be understood less as a distraction or afterthought, and more as an operational priority. These documents and records are not the **intellectual property** of the author, but belong to the institution and have numerous stakeholders beyond the person initially scribing the content. By extension, this type of writing is concerned principally with the presentation of ideas, evidence, observations, and informed conclusions, rather than hypotheses, reflections, or opinions. While healthcare institutions have, not surprisingly, developed their own culture of writing that is distinct from other writing traditions, it is worth noting that there are in fact a number of parallels in terms of style, syntax, and format between healthcare writing and the type of writing done in other professions, including—as strange as it might seem—law enforcement.

The similarities between the writing styles of healthcare and law enforcement, in spite of their obvious differences in terms of job description and background, should not be that surprising given that both fields are tasked primarily with observation, triage, assessment, and response. While their operational methods may differ, the two professions frequently overlap in terms of mutual areas of responsibility, with the police routinely engaging the services of healthcare professionals as part of their everyday duties. Examples include the police relying on healthcare professionals for assistance in specialized investigations ranging from motor vehicle collisions to homicides, as well as in interventions that are just as diverse in nature, from dealing with mental

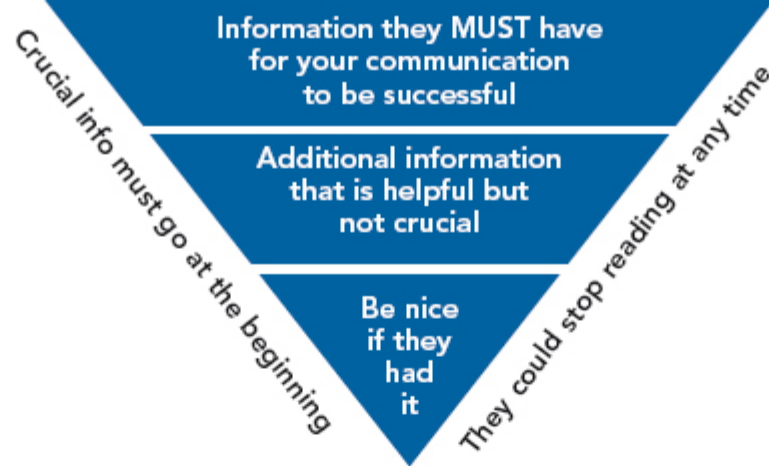
health patients to caring for neglected or abused children. Both professions also overlap in terms of how these occurrences, as well as other mutually inclusive duties, should be documented for future self-reference, accountability, evidence, and to promote accurate institutional record keeping. In brief, healthcare professionals can learn best practices from the writing customs of law-enforcement professionals, whether or not they ever have any direct contact.

In police investigations, for instance, note taking generally focuses on documenting the utterances, complaints, depositions, and also the disposition of the person or persons making a specific accusation. These same notes should then go on to document the actions taken by the investigator in response to this foundational data. In the healthcare setting, one finds a documentary matrix that approximates and in some cases replicates this same system. It is a system that has been in place for centuries and is at the heart of the **common-law** tradition that defines the North American legal system—a system in which healthcare workers are inevitable contributors and stakeholders. The reality is that a great number of medical professionals, like police officers, are specially trained generalists for the purposes of documenting actions or inactions. Even the most decorated and celebrated clinician, like a legendary homicide detective or forensics analyst who is certifiable as an expert witness in court, is still a communications generalist in terms of the requirement to document—and by extension communicate—all facets of his respective tasks and report his findings.

Documentation processes in healthcare settings also tend to follow the same vertically oriented format as other forms of institutional writing that have long-standing traditions. Beyond law enforcement, for instance, newspaper writing and editing is another example of an institutional writing model whose methods cross-pollinate with the healthcare world. Newspaper documents that begin as rudimentary notes taken in the field or at source ultimately make their way through a complex process of writing and editing that ends with final drafts often credited to one or two principal authors, but that rely on the efforts of multiple contributors. In their completed form, these writings are frequently described as inverted pyramid documents in which content and detail are conceptualized in spatial terms. Simply put, the completed versions of these documents can be compared to upside-down pyramids, with the key and foundational information (the base of the pyramid that supports the upper levels) actually located at the top of the document. As the narrative progresses, the pyramid then narrows in scope, scale, and detail, ultimately reaching a point (the apex of the pyramid) where the document concludes succinctly and declaratively.

Take for instance the circuit of healthcare writing as it exists in a traditional hospital setting. The triage nurse as the first point of patient contact in the clinical environment, often sequestered from hands-on clinical work or follow-up interactions by other clinicians, undertakes many of the initial writing responsibilities and is the initial author of what will end up being a composite document. As this document grows over the course of a patient's hospital visit, it takes on the properties of an **anthology**, or a lengthy piece of writing with numerous contributing authors. As the first point in the writing circuit, the triage nurse who has initial contact with the patient may shoulder much of the responsibility in terms of note taking and documentation with respect to patient history, demeanour, and symptoms upon a patient presenting herself at a hospital or clinic; that nurse fills in the base of the inverted pyramid. Conversely, emergency room or ward nurses as tertiary authors typically limit their note taking to reflect the completion of specialized and often singular tasks. These notations—comprising the apex of the pyramid—might describe specifics regarding medication dosages and times, or citations regarding anomalous or irregular reactions or activities regarding a patient.

Inverted Pyramid Writing



Other than in autopsies, surgical or pathological reports, or other cases overtly **forensic** in nature that frequently intersect with criminal investigations or other inquiries with a regulatory or legal purview, healthcare writing of a potentially long-term and legal nature—and thus subject to public disclosure—remains limited in training, scholarship, and practice. Few practitioners, for instance, would normally think of their writing as being published work for a public readership. The modern reality faced by many healthcare professionals is that their writings are no longer strictly internal documents, and anthological works that expose vast differences in the quality of writing between different care providers are bound to raise questions—and concerns. Certain types of patient–clinician interactions, like the types of high-profile documents cited here, are almost without exception authored with a heightened attention to detail given the expectation of their becoming public record; however, sometimes what seem like minor and innocuous interactions can have unforeseen long-term consequences, and make the need for proper documentation and detail all the more important. Unlike in the past, the public disclosure of healthcare writings is no longer limited to high-profile incidents, such as criminal prosecutions, civil litigation actions, or public inquiries—traditionally “forensic” documents. Cases in which healthcare writings are now routinely subject to disclosure or outside scrutiny include the notes of a physician or nurse tasked with caring for the victim of *any* occurrence where medical records are later determined to be relevant. These occurrences include crimes where medical documentation is determined to be probative to the investigation or later in court, including everything from fatal motor-vehicle collisions involving drugs or alcohol to sexual assaults. However, the disclosure and release of these writings need not stem from the commission of a crime per se, as overhauls in **freedom of information** legislation have changed the parameters of healthcare writing such that all documents and records—handwritten or digital—are now subject to release beyond the institution for any number of reasons.

Freedom of information is a blanket term applied to any set of laws that allows any citizen access to government or public institution documents and records. Because healthcare institutions, even private clinics, are regulated by several levels of government, the records of those same institutions are then subject to disclosure in response to specific, reasonable requests by outside parties. While patient confidentiality and the disclosure of personal medical information remains uncompromised and is seldom released other than to the patient or his next of kin, censored, or what are known as **redacted** versions of those same healthcare records are routinely requested for a variety of purposes—and released. In many cases, it is the policy of hospitals to release copies of documents in their possession, through what is known as a **custodian of records**, to patients, the media, and the general public without first notifying the healthcare practitioners who served as the author or authors of those same reports.

The reality is that in our current information society, there has, not surprisingly, emerged a culture of data mining, fact hunting, and collective oversight that makes healthcare records some

of the most sought-after documents among researchers, reporters, litigators and lawyers, and even general troublemakers. Requests filed through the various freedom of information laws cited here do not include the separate disclosure of documents and reports as a result of search warrants, subpoenas, or court orders being executed under the auspices of other statutes, such as the *Criminal Code* or the *Controlled Drugs and Substances Act*. Unlike freedom of information requests, these types of orders can and usually will expedite the release of information—requests that will in nearly every case result in documents and records being carefully analyzed through some formal legal process. The bottom line is that healthcare practitioners writing documents of varying detail are contributing to a public archive and will inevitably have their written work publicly disseminated and communicated, and routinely read by a third-party audience. This should not create a sense of anguish or performance anxiety in healthcare writers; rather, it should remind practitioners that no piece of writing is ever private, nor is it the property of the author. The sooner healthcare writers come to terms with the rules of engagement and recognize that their work can and will find a wider—and frequently more critical—readership, the sooner they can develop their confidence as writers and identify and prevent potential issues before they arise.

One of the additional challenges faced by healthcare writers is that their notes, reports, and documentary records of their clinical activities are scrutinized and criticized by third parties weeks, months, and years after they were written—usually without context. Depending on the demands of a particular clinical environment, these writings are completed on the go, while multi-tasking between patients in noisy and frenetic environments, on limited rest, under time constraints, and often following stressful or tragic interactions. Conversely, these reports tend to be picked apart in office towers, conference rooms, and courtrooms under very controlled conditions, with little or no appreciation for the backstory or rigorous process involved.

Legislation Governing the Release of Healthcare Documents by Province and Territory

Alberta: Freedom of Information & Protection of Privacy Act (FOIP)

FOIP has governed external requests for hospital documents since 2000. It allows for the right of access to all records held on an individual held by any government institution, body, council, or commission, including municipal institutions.

British Columbia: Freedom of Information and Protection of Privacy Act (FOIPPA)

British Columbia is generally regarded as a province with a heightened sense of government accountability. Not surprisingly then, not only is FOIPPA, enacted in 1993 and amended in 1996, relatively all-encompassing in terms of accessing documents at all levels of government, but it is additionally complemented by the separate *Personal Information Protection Act* (PIPA). In addition to the safeguards with respect to the privacy of citizens in FOIPPA, PIPA outlines additional measures and sanctions for violating those regulations and every person's expectation of privacy. Conversely, government workers, including provincial healthcare workers, in the course of their employment effectively have no expectation of privacy, even with respect to what many would consider personal correspondence, in the event that same correspondence was composed on institutional equipment or on company time.

Manitoba: Freedom of Information and Protection of Privacy Act (FIPPA)

In 1997 the Legislative Assembly of Manitoba enacted FIPPA to regulate provincial government documents, including healthcare records. Complaints and investigations are both initiated and adjudicated by the province's Ombudsman, as are all independent reviews and audits.

New Brunswick: *Right to Information & Protection of Privacy Act (RIPPA)*

Having come into force and effect in 2009—remarkably late compared to other jurisdictions—New Brunswick’s legislation supplants “freedom” with the more imperious “right” to information directly in the Act’s title. RIPPA is, however, also more forceful in language with respect to “discretionary” refusals of requests for information, including its considering the wider context of such disclosures, up to and including the Government of Canada. In short, RIPPA safeguards federal information that might have been denied because of a safety issue, and where individuals or groups are now looking to the province to skirt certain considerations and provide the information.

Newfoundland & Labrador: *Access to Information & Protection of Privacy Act (ATIPPA)*

Proclaimed into force in 2007, the timing being on par with most of the Maritimes, the Act includes municipal corporations and commissions, and falls under the authority of the Information and Privacy Commissioner.

Nova Scotia: *Freedom of Information & Protection of Privacy Act (FOIPOP)*

The act has been in effect since 1977, with Nova Scotia having been the first Canadian province to establish its own open records act, doing so well ahead of even the federal government’s *Access to Information Act* that governs the written records of bodies like Health Canada. FOIPOP regulates the release of information and how to handle requests for documentary disclosure from the public as they relate to records held by provincial government agencies. Unlike a number of the other acts elsewhere in Canada, including the Maritimes, FOIPOP does not include municipal government bodies, their being covered instead under the auspices of the province’s *Municipal Government Act*, which was passed in 1999.

Ontario: *Freedom of Information & Protection of Privacy Act (FIPPA)*

Ontario’s act is identical in name and working acronym as Manitoba’s legislation, though there are some distinct differences. One of these distinctions is that records held by Ontario municipalities are governed by the *Municipal Freedom of Information & Protection of Privacy Act (MFIPPA)*, which includes private corporations contracted to provide city-level healthcare services, such as ambulance services and municipal needle-exchange services. FIPPA has been in effect since 1988, while MFIPPA was enacted in 1990.

Prince Edward Island: *Freedom of Information & Protection of Privacy Act (FOIPP)*

As the smallest of the Canadian provinces and with a largely seasonal and agrarian population, it should come as little surprise that Prince Edward Island had no standing legislation regarding access to information until 2002—essentially due to a corresponding lack of requests for disclosure. That said, FOIPP contains some of the clearest and most straightforward language in terms of definitions, exclusions, and explaining the process, having apparently learned from the jargon used in other acts and the ensuing confusion and required amendments. This includes the use of the term “records” in lieu of “documents,” which reflects the multimedia nature of information now housed by government. Interestingly, however, school boards were not initially included as “public bodies” covered by the act and were later added in 2003. Curiously, there is also no reference to municipal government bodies, though cities in the province have been praised for responding to requests for information on a strictly voluntary basis to date.

Quebec's act, proclaimed in 1982 and, like Nova Scotia's, predating federal legislation, is too verbose to lend itself to an acronym and is instead generally referred to not by the name of the act but by the council that oversees its administration. La commission d'accès à l'information de Quebec, or simply la/the Commission, as the most common reference to the act, is also the body that oversees its administration and ensures compliance.

Saskatchewan: *Freedom of Information & Protection of Privacy Act (FOIP)*

Saskatchewan's act, proclaimed in 1991, is abbreviated identically to that of neighbouring Alberta, though like Ontario is complemented by a separate act that covers FOI requests made to municipalities. This legislation, the *Local Authority Freedom of Information & Protection of Privacy Act (LAFIPPA)* tends to be more reductive in its wording and scope as compared to Ontario, however, with "local authority" being defined in section 2 of the act as simply a "municipality."

TERRITORIES

Northwest Territories: *Access to Information & Protection of Privacy Act (ATIPP)*

The act was proclaimed into law in 1996 and contains a number of provisions and restrictions unique to the region's geographical and cultural makeup. This includes the right to refuse requests relating to accessing information held in whole or in part by First Nations organizations, the disclosure or release of which might impair their autonomy and self-governance, or their relationship with the territory government.

Nunavut: *Access to Information & Protection of Privacy Act (ATIPP)*

Having been territorially portioned off from the Northwest Territories in 1999 under the terms of the *Nunavut Act* in 2000, the newly created territory officially adopted the laws of the Northwest Territories until such time as it creates its own. Similarly, Nunavut uses ATIPP as the guiding legislation regarding any FOI requests for records.

Yukon: *Access to Information & Protection of Privacy Act (ATIPP)*

The Yukon Territory, while obviously sovereign from both of the other territories, has nonetheless adopted the same legislation title and even much of the same wording as its neighbours later did. Enacted in 1984, Yukon's version is in fact the original model of ATIPP later adopted by the Northwest Territories and subsequently Nunavut as well.

Healthcare writers, especially in what are often unpredictable primary-care settings, are thus required to strike a balance between creating documents and reports that are useful points of reference for their peers and colleagues and that serve as reminders of their precise actions, while at the same time insulating their work against misinterpretation and unnecessary criticism. Finding and maintaining this balance has often meant, in the absence of substantive training or instruction to the contrary, doing things the way they have always been done, or the way others do them. The reality is that there are more effective methods available for documenting incidents and interactions. The ability to master healthcare writing is grounded in understanding how healthcare writing engages the main forms of English discourse, or what are known as the **rhetoical modes**.

Pronoun: Word that stands in place of and refers back to a noun. The noun for which a pronoun stands in place is called an antecedent. Because they are noun equivalents, pronouns can be subjects or objects in clauses, although unlike nouns their forms will usually change according to their grammatical function (or **case**). There are several subcategories of pronoun, among which are personal (*I, you, her, them*), reflexive (*myself, yourself*), demonstrative (*this, these*), relative (*that, which, who*), and indefinite (*some, each, every*).

Prose: Describes any form of communication, but usually written communication, that uses proper grammatical structure, and has a varied, more irregular metre than poetry, thus differentiating it from verse. Beyond this formal distinction, the term has gone on to more colloquially connote, at least in the health sciences, a comparatively precise and even artful command of written language.

Provenance: A term used to describe the verifiable origins and continuity of a document from creation or confirmed first instance to submission, or how it exists in the present form in which it is being read. It is sometimes also referred to as the “life” and/or chain of custody of a document or record and denotes original source integrity.

Public health: A broad term generally describing the collaborative and integrated approach to healthcare, including a priority on the composition and dissemination of written materials, and an approach that advocates combined strategies for disease prevention, healthcare education and reform, and other innovative approaches to systemic wellness.

Redact: To censor a document, record, or piece of writing by removing or otherwise blocking out specific words or passages.

Reference format: A prose format normally used by encyclopedias, manuals, or published legislation where content is organized into either tables or abbreviated paragraphs to allow for quick referral, and where this same content is carefully sourced, annotated, or accompanied by its own list of secondary references. Not to be confused with **Citation style**.

Refutation: A strategy for dealing with an opposing argument by identifying its conditions of rebuttal, then challenging its validity on those particular grounds, usually on the basis of faulty assumptions or evidence.

Register: The language system used by an identifiable group, occupation, or culture, and normally self-regulated with informal social controls relating to the use of specific terms or technical jargon.

Rhetoric: The art of writing or otherwise communicating with balanced, nuanced, and persuasive language; specifically, the strategic application of the principles of ethos, logos, and pathos in a piece of writing.

Rhetorical modes: The predominant forms of written discourse and those that, to varying degree, allow an author to exercise the three principles of rhetoric through prose. The four major rhetorical modes in writing are universally recognized as **argumentation, description, exposition, and narration**.

Rhetorical situation: Specific context of a document as determined by an assessment of its subject, purpose, audience, and limitations. Determining the rhetorical situation of a piece of

Pronoun: Word that stands in place of and refers back to a noun. The noun for which a pronoun stands in place is called an antecedent. Because they are noun equivalents, pronouns can be subjects or objects in clauses, although unlike nouns their forms will usually change according to their grammatical function (or **case**). There are several subcategories of pronoun, among which are personal (*I, you, her, them*), reflexive (*myself, yourself*), demonstrative (*this, these*), relative (*that, which, who*), and indefinite (*some, each, every*).

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The rhetorical modes are the major categories of discourse and communication to which all forms of writing belong. In breaking down, or disaggregating, documents and records into these categories, four principal writing strategies emerge: **argumentation**, **description**, **exposition**, and **narration**.

Before examining each of these categories and what they offer the theory and practice of healthcare writing, a brief explanation of **rhetoric** as the root principle of the rhetorical modes is warranted.

At its simplest, rhetoric is a concept that describes the craft of communicating ideas effectively and convincingly. Often disparaged in the context of political rhetoric or legal rhetoric, where it is used to describe the ability to manipulate or contort words and ideas, the reality is that rhetoric as a principle of open and effective discourse dates to antiquity. The iconic Greek philosopher Aristotle's foundational work of the same name, *Rhetoric*, dates to the fourth century BCE and was the first major work to advocate a specific methodology for an idea that began over a century earlier. First translated into English in 1909, *Rhetoric* remains a very relevant text today and has helped linguists and scholars of language understand how certain forms of writing are ideally suited for specific audiences and environments. Like the inverted pyramid model of anthological writing in healthcare settings previously discussed, the effective use of rhetoric similarly invokes a triangular metaphor, in this case what Aristotle referred to over two thousand years ago as the **rhetorical triangle**.

Conceived as an equilateral triangle, the rhetorical triangle has three sides of equal length that denote a balanced, symmetrical approach to writing and informing readers. In composing documents, regardless of content, these three sides should frame in the author's content and be drawn on as needed, though one of the sides will inevitably prove more prominent than the others. These three sides of the triangle, the three principles of rhetoric, are known as **ethos**, **logos**, and **pathos**.

- **Ethos**: From the Greek for "character," this element of writing is intended to appeal to a reader's common sense and good judgement. At the same time, ethos should accentuate the writer's own credibility and authority to write about a particular subject.
- **Logos**: From the Greek for "words" and "reason," this element of writing is supposed to appeal to a reader's desire for factual, empirical information, and to impart a sense of logical consistency.
- **Pathos**: Originally from the Greek for "suffering," the term has been adopted into English in its original form for use in describing the awakening of emotion and imagination, and the ability to cultivate sympathy or empathy. In terms of the rhetorical modes, this need not necessarily denote emotive, sentimental, or tragic content as much as it does details—including quantitative details such as facts and figures—that appeal to the emotional intelligence or beliefs of the reader.



In reconciling these three principles of rhetoric—the three sides of the rhetorical triangle—one finds that the ensuing written product should naturally convey one or more of the related rhetorical modes. While there are three principles of rhetoric, there are four rhetorical modes, which can be described as follows:

- **Argumentation:** As the name suggests, argumentation is a rhetorical mode concerned primarily with proving a specific position, or persuading readers to espouse a specific perspective or take a certain course of action. Representative document types include persuasive scholarly essays, advertising texts, opinion or editorial pieces (or what are sometimes jointly referred to as op-ed pieces), and letters written with varying objectives, including complaint letters, job application letters, reference letters, and query letters.
- **Description:** Descriptive writing is commonly found in works of creative fiction, poetry, and memoirs where the objective is to conjure a sense of place, time, and experience for the reader, and is frequently used to complement other more dominant rhetorical modes in a given piece of writing. More commonly associated with pathos than logos or ethos, descriptive writing is frequently paired with narration.
- **Exposition:** Exposition is arguably the most common form of institutional writing—including academic and scholarly writing—that readers will encounter, and it may very well be the most common of the rhetorical modes as a whole. Covering a vast array of representative texts from university essays and reports in any discipline to owner's manuals and technical literature, news reports, legal documents, résumés, business proposals, and scientific literature, exposition—or expository writing as it is also known—serves to “expose” a particular topic. Serving as a focused method of summarizing, explaining, or presenting a factual summary of a single theme, event, or phenomenon, exposition relies on a balanced use of rhetoric to write in a reasoned, informed, and neutral manner, usually for a professional, academic, or otherwise discriminating audience.
- **Narration:** Often associated with fiction, creative non-fiction, or biographical writing, narration is essentially the means by which rhetoric is used to present a coherent, and typically chronological, story. In much the same fashion as a narrator serves as the storyteller in any number of media, and whose main function is to allow the reader—or viewer and/or listener in the case of audiovisual media—to follow a given story, narration in the context of rhetoric serves largely the same demonstrative purpose.

In assessing these four rhetorical modes, exposition emerges as the one mode that defines day-to-day healthcare writing in an institutional, clinical setting. Other rhetorical modes certainly have their place in alternate streams of healthcare writing, including, for example, in **narrative medicine** and the authorship of **pathographies**, both of which are covered later in **Part II**. The reality is, however, that the bulk of the healthcare professional's writing duties with respect to notes and reports consists of detailing precise movements, actions, and dosages, statements or utterances made by patients or other stakeholders, observations with respect to symptoms, injuries, or demeanour, and generally accounting for one's time. With few exceptions, the expository mode is therefore the most direct and efficient means of summarizing—objectively and matter-of-factly—what are often referred to as the “five Ws and one H” of a healthcare occurrence: the who, what, why, when, where, and how. Subscribing to this model will pose the fewest problems for healthcare writers as their documents follow a circuitous route from a given healthcare institution into the public sphere.

Another term that healthcare writers should acquaint themselves with when adopting exposition as their main rhetorical device—the blueprint for the bulk of their daily professional writing—is a form of structured composition known as prose.

Prose is, quite simply, the proper grammatical structuring of sentences, including the required use of **syntax** to create coherent word orders and statements, as opposed to forms of writing, most notably song writing and poetry, that typically involve the use of rhyme and meter. While this distinction might seem obvious when referencing most conventional forms of institutional writing, especially when composing documents of clinical, professional, and potentially legal (or forensic) importance, prose has become synonymous with articulate, conscientious narratives. In the sciences, when referencing a certain style of writing, especially when drawing reference to its elegance or professionalism, one will typically refer to it as “prose” as a means of endorsement, and in order to distinguish it from run-of-the-mill or unremarkable pieces of writing. Even though most structured and paragraphed writing—exposition for the most part—amounts to prose by definition, the term has taken on a critical element and is often used to acclaim a certain sample or style of writing as being inherently eloquent and persuasive. The ensuing written product is commonly referred to as **expository prose** as a combination of both exposition and prose narrative, and describes the ability to write neutrally and factually but also in a style that draws on the principles of rhetoric. Expository prose should therefore be the end goal of every healthcare writer, as we will see later with examples.

UNDERSTANDING EXPOSITORY PROSE

One of the key features that distinguishes expository prose from other forms of exposition is the fact that it relies on—as all prose does—proper grammatical structure. Unstructured forms of expository writing, by comparison, would include point-form or scratch notes, a common form of writing in front-line, primary care (and even tertiary care) institutional settings. Notes of this nature can certainly impart the principles of rhetoric and in some cases can actually prevail as the best—or at least the most authentic and unedited—record of an event. That said, the majority of written communication in healthcare necessitates a fuller account of one's actions, decisions, and interactions, notwithstanding technical or clinical information that often needs to be spelled out to mitigate misinterpretation.

In developing both interpersonal and professional writing skills in the healthcare setting, understanding expository prose as a vehicle for effective communication therefore requires an understanding of how, to quote from famed media analyst Marshall McLuhan (1964), “the medium is the message”—in other words, the format or medium used to convey a particular communication will in turn shape its context and, by extension, the content itself. In healthcare writing and communication, expository prose can then generally be broken down into three main

formats: handwritten prose, electronic prose, and templated prose in the form of preprinted charts and standardized ledgers, whether analogue or electronic.

Analogue documents and records can, for the purposes of this chapter and in the context of healthcare writing generally, be understood as writings that exist in a hardcopy format, usually as they were originally created. Conversely, electronic documents and records exist in soft-copy form unless converted to a hard-copy version through printing or manual transcribing. Even in a digital age, paper documents still persist as the daily reality for many healthcare practitioners across a variety of care-delivery settings. There are a few reasons for this that are explained later in this chapter, but we are less concerned about the reason behind the persistence of analogue writing than about how it can come to be an effective medium for expository prose, and a competency that all practitioners can ultimately come to master.

EXPOSITION IN HANDWRITTEN DOCUMENTS

Even in a knowledge-based economy and in an age of “smart” hospitals, where entire wards and their respective life-safety systems are digitally integrated, it is interesting to note that the handwriting of documents still exists and in some areas even prevails as a commonly accepted practice. This is once again where parallels can be drawn between healthcare and law enforcement, as both represent public sector professions where, in addition to other tasks, practitioners are expected to function as front-line documentarians while relying primarily on analogue writing methods that don’t necessarily seem to be in keeping with current technological standards. This expectation often yields rigorous demands for precise notations that need to be made in real time as dynamic events unfold, and which require the use of traditional stationery tools such as a pen and paper. While seemingly retrograde in a clinical environment pervaded by state-of-the-art medical and computing technologies, the reality is that traditional handwritten notes are just one part of the writing process that at some levels is electronic and paperless. We might liken this to a hybrid model of institutional writing where, depending on the division of labour, some in-patient encounters are handwritten and others electronically scribed. Whether a given clinical environment is paper-dependent and relies on handwritten records, is completely paperless (some US hospitals even issue death certificates electronically), or is the more common hybrid model that relies on both analogue and electronic writing seems to vary by institution.

While healthcare professionals have the advantage, in comparison to law-enforcement representatives and other professions that still require handwritten notes, of being able to author handwritten notes indoors and in climate-controlled environments away from the elements, they are similarly required to keep detailed manual records. The notepad, notebook, or ledger and pen have for this same reason historically ranked amongst the healthcare professional’s most ubiquitous implements and the starting points for authoring more elaborate reports. Those institutions still relying on a system of handwritten reports or that employ a hybrid model are doing so not because handwritten notes are necessarily more efficient or accurate in terms of capturing clinical data and recording observations—because they aren’t—but because of the costs associated with the infrastructural and training requirements of certain software platforms. As such, handwritten notes and documents, and hard-copy records generally, all remain key forms of institutional communication in healthcare, and carry with them certain expected competencies in terms of clarity and thoroughness. Because medical, paramedical, nursing, and other health-sciences students or early-career healthcare professionals may be unsure of what type of institution they may end up working in over a long-term basis, the ability to master clear and cogent healthcare communication practices in a handwritten form therefore remains a core competency.

Notations made by hand, either with respect to a specific time, medication dosage, or change in condition, are known as entries, and should be made as soon as possible following an

observation, incident, or anything else worth noting—what might generally be described as an in-patient encounter. This same dynamic process is also what separates handwritten notes from more detailed reports that tend to be authored electronically later on, as it is not necessarily practicable to commit to authoring a full report, or even sit down at a terminal while actively engaged in providing patient care. It is in part then a matter of both practicality and accuracy—factors that are often mutually inclusive—that the tradition of handwriting notes remains largely unchanged in some settings in spite of significant institutional technologizing in hospitals and clinics.

An in-patient written **entry** can be any word, number, or combination of words and numbers that represents a single written event. As a general rule, however, the number of total entries, and the length of each entry within the set, should be proportionate to the matter being documented or attended to. Each entry, as an idea, statement, description, or observation is then part of a continuous, running document, with breaks between entries being distinguished by using a space or a new time entry or both.

E Rm 1	Hypo tape, gauze - clean up required room not clean
B-24	Diaper change x3 - no bed pan in cabinet - call porter
C-6	I-V bag required for mouth swabs. * Exp + 63514 for extra staff -
D-4	Tegaderm for mobile cart needed.
Rm 110	MRSA zone for 19 ⁰⁰ shift

Ward notes, typically kept at a nurses' station or other central location in a care delivery environment, are yet another example of anthological writing in healthcare and are open-access, interactive documents where intermittent handwritten entries are made over the course of a given shift or 24-hour period. Typically itemized by room, locations are listed in the left margin and the accompanying narrative text in the right margin.

If nothing else, handwritten documents and records afford both brevity and portability as enduring necessities of the care-delivery environment. Today, a host of devices that mimic the portability and accessibility of hard-copy documents, but which allow for electronic entries that streamline this same process, are also readily available and comparatively affordable. In some cases, these devices may be used in lieu of making an analogue entry, such as using a smartphone, tablet, or other type of personal digital assistant (PDA) that can double as a word processor. Unless otherwise stated in hospital or other institutional policy, however, this practice should generally be avoided other than in exceptional circumstances. In those rare cases, any electronic entries made should later be transcribed to the medium normally used, such as a notebook or ledger, as a matter of consistency. Unless the device used to create a given patient record is the property of the healthcare institution, the recording of clinical and confidential information on one's own personal device—even temporarily—can also be fraught with legal and ethical issues in terms of confidentiality and the continuity of records. Disclosure or discovery requests pursuant to FOI legislation or official prosecutions or litigations could also open up all

other records, personal or otherwise, housed on the device, to third-party scrutiny. In Canada, precedent-setting rulings that include Supreme Court decisions in the cases of *R. v. Stinchcombe*, [1991] 3 S.C.R. 326 (S.C.C.) and *R. v. O'Connor*, [1995] 4 S.C.R. 411 (S.C.C.), the latter of which relates specifically to the historical records in the sole custody of medical practitioners, have clearly laid the ground rules for this current reality that all healthcare providers should be aware of.

Because of the scrutiny that healthcare notes undergo once they leave the custody of the author, there is an expectation that they are the most candid, the most authentic, and the most raw and unvetted version of an event. The fact that handwritten notes, by virtue of their immediately permanent nature, also cannot be—without leaving some sort of trace—deleted, edited, corrupted, excised, pasted, or be subject to any of the other modifications possible with electronic writing, is often what makes handwritten notes the preferred documentation system with respect to key details that can later be drawn on when composing more elaborate documents. Because individual healthcare documents and contributions made by individual healthcare writers are frequently part of a larger anthology as previously described in this chapter, it is also important to remember that ledgers and notebooks may later be used by other practitioners. For this reason in and of itself, notes made with respect to patient care should be reconciled in a single location, and not partitioned into different locations such as a portable electronic device, personal scratch pad, or other unregulated media. This is also in part the rationale for using standardized charts and forms, as explored later in this chapter.

While creating handwritten notes or documents using electronic tools is not generally advised, there are circumstances when handwritten and electronic forms of healthcare writing will be naturally reconciled. An **annotation**, for instance, is a notation or entry, made as a supplemental piece of writing for the purposes of providing additional or clarifying information for an existing piece of writing. A handwritten annotation can either be overlaid on, or otherwise inserted as new information into, an existing document or record. While annotations can also be word processed, and while a number of bodies of work are designed specifically to accommodate or include electronic annotations as marks of thoroughness (see annotated bibliographies in [chapter 8](#) as an example), annotations in the context of healthcare writing tend to be made by hand and for single, one-time use only. This time-limited nature of handwritten annotations as part of the patient care model is one of the key distinctions of healthcare writing as its own institutional genre. These annotations often reflect situational, circumstantial, or otherwise ephemeral information entered as a matter of reference for a physician when conducting rounds, or for a shift of nurses caring for a patient on a ward, and whose condition or circumstances are variable and subject to change.

Most commonly, annotations are made as brief sketch notes, or point-form entries that can be read quickly and efficiently, leaving little room for interpretation. The rationale behind making and relying on these types of quick sketch notes is that they are able to offer explanatory information not otherwise captured in the hard copy of an existing document, which may only capture basic data or information that has changed since the time of its original printing or composition. The additional rationale for making handwritten annotations in lieu of amending the original electronic record at source is that these annotations, aside from reflecting changeable information, are frequently intended to have a limited audience and a one-time use in facilitating the efficient workflow of the care team.

Even printed documents of an ordinary word-processed or electronic source will often require handwritten annotations or amendments as information or assessments change, but with its not otherwise being practical to modify and reprint the original document. In these circumstances, it is entirely acceptable for word-processed and handwritten writing to simultaneously occupy the same narrative space.

PRINTED PATIENT LIST

LIST NAME: ADMITTING PHYSICIAN, PATIENT CARE FOR: DR. J. SMITH

LOCATION D/C STATUS	PIN	NAME	SEX/AGE	DOB	DAY ADMIT	ATTENDING MD	DIAGNOSIS
V-C42 Red	11701	DOE, Jane	F/33	81/01/01	14/04/03	Pregnancy	

→ APd #1 - forceps urinary irritation/pain - poss. d/c + mrv.

In this sample, we see that a printed hardcopy of an electronic record has been the subject of annotations that are handwritten directly into any available or applicable space and with little to no real formatting requirements; or, more frequently, annotations of this nature will exhibit a format that mirrors the design of the original document. Whether making conventional report-style entries in a book or a ledger, or annotating the hard copy of an electronically composed document, exposition in handwritten notes is rooted in brevity, clarity, and accuracy, the idea being that they can be written—and read—quickly and efficiently.

SOAP NOTES

With respect to handwritten forms of exposition, in addition to annotations and basic sketch notes, there has emerged a specific type of document within healthcare writing that might be described as the foundational form of everyday writing. With its being used across all spectra of patient care, this document type represents a form of exposition that, while written as prose, follows a standardized format; it is the editorial template used for the authorship of most types of handwritten notes when describing interactions with patients. Using the **acronym** SOAP as a **mnemonic** reminder of what elements need to be covered in this type of writing and in what order, these notes are often the first type of exposition that new healthcare workers become acquainted with in the care-delivery environment. In assessing the core components of these notes, the acronym SOAP can be broken down by letter as follows:

Subjective: The first portion of the document reflects the author describing a patient's stated complaints or feelings, including how she describes phenomena like pain according to her own subjective standards and definitions, such as on a scale of 1 to 10.

Objective: Following from the patient's descriptions, this portion of text is where the attending healthcare professional interprets the data provided by the patient. This includes the practitioner listing her own observations based on her individual education, training, and experience.

Assessment: Stemming from the last, in this section the practitioner lists possible explanations for the symptoms described and observed, including her informed conclusions based on the balance of probabilities, including her ruling out unlikely explanations.

Plan: The concluding section focuses on a plan of treatment or a proposed course of action to provide care. This may also include information justifying a referral to a specialist, or exploring other diagnostic or treatment options.

With the SOAP blueprint in mind, an everyday handwritten document in the healthcare-delivery environment, using a hypothetical example of a patient complaining of abdominal pain and with no known injury or specific cause, may be composed in the following manner:

Subjective: Patient complaints noted at the time of admittance and time of assessment, the latter noted in the left margin along with the apparent medical problem, or chief complaint

Objective: Critical observations of patient, including quantifiable and verifiable physiological measurements or readings

Assessment: A preliminary conclusion based on the available data, including both clinical and anecdotal data

Plan: An initial course of action based on the assessment, including specifications with respect to medication, dosage, admittance, or referrals to specialists

TIME	FOCUS / PROBLEM	CLINICAL PROGRESS RECORD (Sign or Initial all Entries)
14/20	Nausea	Pt attended ER in am w/ o/o stomach pain radiating to groin Vomit x3 since ER admitting w/ increase discomfort and pain described as stabbing 6/10
1		Pt presenting w/ ash colouring nausea and abdominal discomfort rated 8/10 q B/M in 24 hrs Pulse Ox 99% HR 100 B/P 162/100 pupils regular and reactive to light. Cap refill normal good reflex & circulation to extremities. Urine output 700cc clear.
		Poss. Acute Appendicitis - Rr. Abdo pain & on palpation.
		Ref: To General Surgery & Gravid IV = Morphine drip. To be moved to General Surgery

EXPOSITION IN ELECTRONIC DOCUMENTS

Electronic notes might be described as encompassing the largest assortment of healthcare documents. Generally speaking, electronic notes and electronic writing in healthcare refers to the authorship of reports that are intended to remain in electronic from start to finish, and which are expected to be word processed or computer mediated from the outset. Thus, electronic exposition would not include, for instance, a handwritten document, such as a SOAP note, which was later electronically transcribed.

The word “digital” has recently become a blanket term to describe anything electronic. The traditional definition actually describes a form of data or segment of media that consists of repeating numbers, as indicated by its word origin *digitus*, from the Latin for finger—as in for counting. Digital writing by extension refers to words or other media used as symbolic representations of data, which in turn has implications for content. It is therefore important to distinguish between *digital* documents, including those making use of hypertext, extensible hypertext, and source code, versus *electronic* documents, which can be more simply described as writing that uses word-processing software or is otherwise created and stored in a soft-copy format.

This section deals with electronic writing, which is the majority of the more detailed report writing done in primary care settings. Electronic writing also includes a variety of documents and records found in secondary and tertiary care settings, up to and including the forms of interpersonal writing covered in the [next chapter](#). Electronic writing will in some cases also draw facts and other data from handwritten notes that can serve as the visual index for electronic documentation (versus transcription), and which provide the general outline used in the authorship of electronic documents. In most circumstances, however, electronic writing of any significant detail will be done in controlled environments away from patients, and typically with a longer interval elapsing between an incident and its documentation in comparison to handwritten notes that need to be made as soon as practicable.

Exposition in electronic writing, as opposed to handwritten notes, tends also to be something the writer does in a single sitting and as single focused task rather than being completed incrementally or intermittently over the course of a shift or workday. There are of course exceptions to this scenario, as the frequently dynamic and unpredictable nature of even secondary and tertiary care environments can prove ripe for interruptions, departures from routine, and leading to time-sensitive documents being written in multiple versions. In primary care environments like busy urban hospitals, these scenarios are often the rule, not the exception;

however, there are a number of writing strategies that are exportable to all healthcare settings when authoring electronic documents—strategies that can help ensure both accuracy and expository efficiency.

Electronic writing in healthcare, at least in primary and secondary care-delivery environments, is relevant to all specialties and care-delivery environments. It is covered in more elaborate detail in [Part II](#) of this book, where specific subgenres of healthcare writing encompassing primary, secondary, tertiary, and what is sometimes distinguished as quaternary care are discussed; however, before progressing to specific forms of narrative and healthcare communication that employ electronic writing as a rule, it is important to first have a grasp on the nuances of electronic writing in relation to patient care and institutional operations.

Exposition in respect to electronic writing in healthcare can generally be divided into two subcategories: interpersonal report writing and **electronic medical record** (EMR) writing. Again, while countless types of documents that intersect with a healthcare professional's duties, whether directly or indirectly, will necessitate the use of a computer or other word-processing device, not all of these forms of writing will necessarily be expository in nature. Of the multiple types of electronic writing conducted by healthcare professionals on a daily (and nightly) basis, it is these two types—interpersonal reporting and EMR writing—that are the most common and which demand the greatest command of clear, coherent, exposition.

EMRs, almost without exception, employ any number of standardized electronic templates. While expository writing in the context of standardized forms will be covered in the next section of this chapter, it is worth noting that a number of EMR platforms, while standardized, are also highly customizable to suit specific specialties or care-delivery models, and will demand highly detailed but also succinct entries that represent self-contained narratives within finite text fields. EMRs and interpersonal writings also both require exposition as their primary rhetorical mode. In addition to the fact that handwritten documentation still exists in many tertiary care environments, there are still some branches of primary and secondary healthcare that for any number of reasons, but typically as a matter of cost-effectiveness, still rely on handwritten rather than electronic reports. For instance, ambulance call reports (ACRs) in the case of para-medicine typically involve hard-copy standardized forms and handwritten reports, while triage nurses as the first point of contact in primary care settings often employ standardized forms that are both electronic and analogue in format—a reflection of the duplication of process and administrative redundancies that bog down many healthcare settings in terms of time management.

- Help - Logout		 GME0000 Smith, Caroline Sex: Female DOB: 1940/01/01 Next of kin: John Smith Phone: 365-565-9090 Address: 19 Provincial Rd. Edmonton AB T6M 1R7		Name: Jones, Evans Phone: 333-465-5545 Address: 11 Terrence Ave., Edmonton, AB T4Y 8U9 Other Healthcare Providers <table border="1"> <thead> <tr> <th>Name</th> <th>Disp.</th> <th>Last Encounter</th> <th>Next encounter</th> <th>Right of Access</th> </tr> </thead> <tbody> <tr> <td>Diaz, Ellen</td> <td>Cardiology</td> <td>01/2006</td> <td>07/2006</td> <td>Y</td> </tr> <tr> <td>Fournier, Janice</td> <td>RN</td> <td>08/2005</td> <td></td> <td></td> </tr> <tr> <td>Cohen, Richard</td> <td>Dermatology</td> <td>07/2005</td> <td></td> <td>N</td> </tr> </tbody> </table>		Name	Disp.	Last Encounter	Next encounter	Right of Access	Diaz, Ellen	Cardiology	01/2006	07/2006	Y	Fournier, Janice	RN	08/2005			Cohen, Richard	Dermatology	07/2005		N																																																	
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Here is an example of an EMR using fictional patient information. (Source: Canada Health Infoway)

These few exceptions aside, the vast majority of practitioner reports in primary and secondary care environments are word processed and thereby offer distinct advantages over handwritten reports, while at the same time elevating expectations and posing their own unique challenges. Once again, the current standard in terms of streamlining electronic documentation in primary and secondary healthcare settings is the EMR, and while a number of options exist, the most common with respect to both inpatient and outpatient reporting in both primary and secondary care environments is a software suite known as PowerChart®. As an EMR document workflow system, Cerner's PowerChart® integrates narrative prose with pre-populated fields to combine elements of both analogue and electronic healthcare writing in a printable soft-copy format.

Beyond EMRs and other electronically documented clinician-patient encounters that contribute to a larger written anthology, the most common form of expository writing found in healthcare environments is in interpersonal communication, including the composition of memoranda, emails, and conventional letters written using word-processing software. Frequently, these forms of communication serve as more than formalities and function as supplemental reports justifying courses of action, as well as providing timely updates to chief physicians or administrators by way of email, and thus amount to electronic exposition in that a summary of events must be outlined clearly and matter of factly. While professional email composition is covered more thoroughly in the following chapter, it should be noted that emails often combine elements of both letter writing and the type of expository report writing encountered using PowerChart® or other proprietary platforms for use in authoring and editing EMRs.

EXPOSITION IN CHARTS AND STANDARDIZED FORMS

The last form of exposition most commonly found in healthcare settings is report writing by way of **charting**, or handwriting with the use of standardized preprinted forms. Generally speaking, charting describes the process of writing—as the name suggests—on a chart, although the

definition of a chart has certainly changed in recent years. In generations past, a chart would simply be a ledger or other written record of a patient's attendance at an institution or time in a care-delivery environment. Eventually the term "chart" came to be used interchangeably with "sheet" and other terms that similarly denoted hard-copy documents, usually a page or two in length, consisting of some cursory notes.

As charts have become increasingly electronic in their formatting, the more appropriate term is now "record" (patient record, medical record, etc.) and, while a record is typically used in lieu of chart, the term "charting" still prevails. This is in large part because the type of writing itself has changed very little, mostly as a result of records and charts relying on templates, fixed-choice categories, and a restricted space for writing narrative. As such, even with a change in medium, there has been comparatively little room—literally and figuratively speaking—for charting to evolve in terms of expository prose. In essence, charting involves the writing and maintenance of a body of information that is indexed to an individual patient, a body of documents that may exist in any number of media, whether analogue, electronic, or both.

Upon registering at a hospital, clinic, or other healthcare-delivery environment—or even just invoking interaction with an ambulance service—each patient will have an anthologized record of her visit recorded that reflects that individual encounter and the care received, if any; this record is then consolidated with other historical records to become a much larger compendium of long-term information—a master record that serves once again as an example of a healthcare anthology: over her lifetime a person may deal with hundreds of healthcare professionals, each of whom contributes in writing to the chart. In other words, every healthcare record is to some extent a dynamic, organic, and ever expanding set of writings that serves an archival purpose, and all the writing that goes into the authorship and maintenance of this record is by definition charting. To keep such an archive manageable, one of the key strategies for effective exposition in charting is good editing—in large part why each record defaults to template-based, standardized forms. By limiting the information that can be written, standardized forms force healthcare professionals to write with **concision**, which means that they need to learn to be selective and restrained with their words.

Social media, discussed later in [chapter 5](#), and other forms of electronic communication often use this same system of concision to place limits on content as a matter of practicality, just as many internet submission forms will display a text field that only allows for a finite number of characters. Whether in analogue or electronic format, charting templates often place these same constraints on healthcare writers and require them to provide key information in fairly constrained space. While initially appearing as overly proscriptive and limiting to those unaccustomed to having their writing governed in such fashion, the reality is that such a system is the ideal format for developing good expository writing skills—learning to write a narrative succinctly and effectively, and providing more information with less space. Sometimes these forms are preprinted and expected to be completed much like handwritten notes, and sometimes the charts are electronic in format and require completion electronically. Either way, the strategy is the same: write with concision.

Concision is a strategic approach to the writing process that is typical of many institutional environments, and a best practice in expository writing generally. With authors prioritizing brevity and clarity when chronicling interactions and observations, and being restrained when describing people, places, concepts, or things generally, concision is the practice of using no more words than are necessary when authoring a narrative. Unlike rhetorical modes such as description and narration that require more illustrative, persuasive, and provocative word and sentence structures, exposition is reserved for narratives that inform and explain, and this can be achieved often through concise writing more than it can by going into elaborate detail. In other words, effective exposition often means that less is actually more, and the required use of standardized forms is one way that healthcare writers can hone this skill. For instance, consider the following

paragraph as an example of expository writing, and describing a not-uncommon healthcare scenario:

A 19-year-old female patient came into the emergency room with a friend who drove her, and complained in detail that she had been feeling very sick to her stomach for several days, having begun vomiting earlier in the afternoon. The patient appeared pale and dishevelled and explained that this has never happened to her before, and that she hadn't been able to hold down as much as a glass of water since yesterday morning.

Factually, grammatically, and even stylistically, there is really nothing wrong with the sentences comprising this paragraph, and it is essentially fine as it stands were this a form of electronic exposition. However, when charting this same information within the fixed and finite text field of a standardized patient admission form or other record, one would be wise to minimize how much space is used to relay these same facts, because supplemental text may later be required, or circumstances may quickly change that necessitate further documentation. For these reasons, concision is an effective means of providing breathing room within a written record, while at the same time providing a fact-driven and explanatory synopsis of the key issues, which is of course the main objective of expository writing. Consider the same narrative synopsis re-drafted with concision in mind:

19-year-old female patient attended the emergency room complaining and presenting with symptoms of severe nausea with vomiting, and with no known cause. No previous history disclosed and patient unable to ingest food or water in over 24 hours.

In this version, the same information is presented in roughly half the number of words and with half the space used compared with the original paragraph. While some strategies are being used in this second example that require a strong command of syntax and understanding the nuances of sentence clauses (see [Part III](#) of this book and the self-check exercises) the reality is that the second version reflects good editing and reordering, as well as choosing appropriate, single-word synonyms or alternate and usually more concise wordings altogether (“unable to ingest food or water in over 24 hours” versus “she hadn’t been able to hold down as much as a glass of water since yesterday morning”). While these changes seem subtle, their cumulative nature enables the author to save space and—with practice—time as well. With experience, these editorial strategies ultimately become second nature for healthcare professionals when documenting events and symptoms on standardized forms. This is, in part, the result of the institution or healthcare-delivery environment in which they work influencing their professional vocabulary, something known specifically as a register.

A **register** is a form of language appropriate to a specific environment, including occupational or social settings where people adjust their manner of speech or writing to reflect the norms of their peers. Forming part of a larger field known as sociolinguistics, the use of professional registers among specific occupations is a relatively well-studied phenomenon, and in healthcare—just as in law, academia, engineering, and other professions with their own associated nomenclature and glossary of terms—there exists a certain “lingo” that healthcare professionals use to communicate with each other. In a written form, this lingo—the healthcare register—becomes part of the standard institutional vocabulary that appears consistently in all types of patient records and other forms of writing.

Healthcare settings are, however, unique in that, unlike some other institutions, there can be several different registers operating simultaneously, and in both oral and written forms. Research going back several generations has broken down these registers based on factors like the customs of the environment, how well those communicating know each other, the presence of a rank or command system, and the general formality of the setting (Joos, 1967). Bearing these variables in mind, there are five main linguistic registers identified in the English language, moving from most formal or structured to least formal and structured as follows:

- **Frozen Register:** A fixed and unchanging language system rooted in specific written words that must be duplicated verbatim each time they are reproduced or recirculated either in writing or orally. In healthcare settings, this includes everything from the fixed wording of the Hippocratic Oath to terms written in an autopsy report specifying cause of death or referring to specific hospital policy wordings or sections of related legislation.
- **Formal Register:** Unidirectional communication, whether oral or written, from one party to one or more persons, and containing specific technical or instructional information that is specific to the audience. Interruptions or edits are considered inappropriate, and the clarity or accuracy of the communication is questioned only when absolutely necessary. Examples in healthcare include lectures at medical symposia, conferences, or university classes, directives issued in writing from supervising clinicians or administrators, or prescription information sent from a physician to a pharmacist.
- **Consultative Register:** Interactive, participatory communication involving two or more persons, and generally of an explanatory and respectful, yet slightly less formal, nature. This register relies on verbal and visual feedback for communicators to find common ground. Examples in healthcare include patient consults, discussions between residents or fellows and more seasoned physicians, or interactions between specialists working in the physiotherapies or psychotherapies and their clients.
- **Casual Register:** Generally found outside occupational or professional settings, although it can operate in the background in such places among workers of the same peer group or who otherwise have a social relationship. The use of language is comparatively informal and unstructured and the use of slang, profanity, and anecdotal references are customary. Examples in healthcare might include nurses talking on break in a lunchroom, cards sent from ward staff to an ill colleague, or an email unrelated to work sent from an occupational therapist at one hospital to a friend based out of a different clinic.
- **Intimate Register:** Reserved for only the most close-knit groups who have established their own language system defined by nicknames, inside jokes, and ciphers. Most common among long-standing friends, family members, or those in an intimate relationship, this register can still be found in healthcare settings under specific circumstances. These circumstances might include emergency room physicians, nurses, or paramedics who have worked the same shift for many years and who are essentially family by default, having established their own code words for people and items; it could also include a scenario such as a text message or social media post between colleagues that makes use of emoticons or other word substitutions to convey mutually understood inside information.

Across a variety of healthcare settings, one may in fact find all five of these registers operating simultaneously depending on the number of people present, the time of day, and the nature of the work being performed. The emergence and sustainability of differing registers can also be an indicator of the prevailing management style and morale in a given healthcare setting, with the willingness to adopt or revert to less formal registers when appropriate often being indicative of enhanced collegiality. Unfortunately, misjudging a colleague's awareness of a register's jargon, or mistaking that colleague for a member of the register's in-group is also what often leads to

complaints or of unprofessional conduct or workplace harassment—when even well-intentioned statements or writings are determined to be unwelcome and inappropriately informal for the setting and its perceived register.

While direct interactions between practitioners and patients, whether orally or in writing, tend to fall into either the formal or consultative categories, there are some types of healthcare communication that engage both patients and peers alike, yet that have no formal classification in terms of register. Although the design of charts and standardized forms represents a frozen register given that the content is fixed and unchanging, they have the unique characteristic of enabling acceptable forms of informal writing when they are actually filled in. In fact, a specific way that healthcare practitioners distinguish themselves from the registers used in other professions and from the categorization of registers generally is through the pervasive use of shorthand during the charting process.

Historically speaking, **shorthand** writing is a standardized system of symbolic documentation that dates to ancient times. It has most recently been used in professional contexts such as courtroom stenography and when scribes, administrative assistants, or other record keepers are required to take minutes or dictation at business meetings or other formal interactions that require transcripts of some type. While electronic documentation has to a large extent done away with the need to learn and master traditional shorthand, there are some professions that still use approximations of it, including the use of accepted abbreviations and **initialisms** when having to write technical information quickly and with limited space. Patient charting in standardized forms, requiring handwritten data in lieu of an electronic entry, is one such example. In these circumstances, abbreviations and initialisms that are accepted as part of a professional register constitute permissible shorthand techniques that can further assist with the editing process, and can help ensure that concision is maximized when writing within a restricted narrative space.

While not necessarily an example of good English by definition, abbreviations, initialisms, and other contemporary forms of healthcare shorthand amount to an accepted practice and even a professional survival skill when charting in an analogue context or when completing standardized forms by hand. In fact, while standardized electronic forms that are completed as part of a desktop application also limit the author to a finite number of characters in most cases, preprinted forms pose the additional challenge of requiring the writer to adjust his font style and size to suit the dimensions of the space provided. This means that larger handwriting will use up even more text field space, and thereby exacerbate the existing spatial limitations placed on the writer. In most cases, a professionally acceptable and legible shorthand is the one editorial control that proves most efficient across all spectra and specialties of healthcare.

In terms of standardized or preprinted forms that have fixed-choice categories (typically boxes to check or specified areas to complete) as well as fixed text fields that require writing with concision and frequently resorting to shorthand, most tend to be found in primary or secondary care environments, including walk-in clinics, urgent care centres, and emergency departments. Most often, these forms remain analogue in format for the long term and are filed as hard-copy format in that they may require not only multiple authors as anthologized documents, but also the inclusion of secondary analogue attachments. Such attachments could include everything from an imprint of a patient's health insurance or healthcare benefits card on the face page of the related form to, in the cases of patients transported or transferred by ambulance, the original electrocardiography (ECG) strip sometimes used by the attending paramedics.

These anthologized records of admittance—typically in the form of analogue booklets—are often referred to as a **flowsheet**, and come together piecemeal with a number of healthcare authors. The flowsheet represents one of the more common examples of how designated narrative spaces are typically quite limited in terms of room for making entries in order to keep records of admittance streamlined and expedited. In most circumstances, this limited narrative space is referred to as a **clinical progress record** or similar (clinical progress report, clinical progress

notes, etc.), where attending clinicians, nurses, and other healthcare practitioners are expected to make (and initial) entries that in most cases should not exceed one line in the ledger. While this may vary on a case-by-case basis and the expected outcome of the diagnosis or a patient's individual progress, clinical progress record text fields are designed to accommodate a potentially large number of authors, and therefore require considerable concision with respect to the length of a single entry. For this reason, accepted shorthand of one type or another will often become an accepted practice during the document's itinerary.

AIRWAY / RESPIRATORY			
No audible stridor/wheeze/grunt. No tracheal tug/indrawing/nasal flaring. No mottling/cyanosis. Respirations 12-20 minute at rest, quiet and regular. Breath sounds clear and audible both lung fields on auscultation. Sputum absent or clear. Nail beds and mucous membranes pink.			
Initial Assessment ☐ WDL		Time: _____	Initials: _____
☐ Wheezing	☐ Stridor	☐ Snoring	☐ Intubated
Respiratory Rate: _____		☐ Capillary Refill _____ sec.	
☐ Tachypnea	☐ Irregular	☐ Shallow	☐ Laboured
Breath Sounds: ☐ Normal		☐ Crackles	☐ Wheezes
☐ Equal		☐ Decreased	☐ Absent
Appearance: ☐ Indrawing		☐ Accessory Breathing Muscles	☐ Pursed Lip Breathing
Colour: ☐ Flushed		☐ Pale	☐ Mottled ☐ Cyanotic
If 1 or more risk factors, do established out-patient falls assessment YES NO ☐ ☐ Greater than or equal to 65 years ☐ ☐ Previous fall in last 90 days ☐ ☐ Mobility challenges (i.e., uses walker / assistive device) ☐ ☐ Cognitive impairment / acute confusion / intoxication ☐ ☐ Clinical concern: (specify) _____ _____ ☐ Does not meet pre-screen criteria, out-patient falls assessment deferred, will reassess fall risk as clinically indicated			

The ECG strip, often accompanied by an ambulance call report (ACR), is appended directly to the hospital form or compendium of forms that begins the patient's record. In cases of ambulatory patients, it is paramedics rather than triage nurses who will be the first authors in the anthology as authorship follows a chronological format.

One word of caution about the use of shorthand is that, as effective as it can prove to be under a variety of charting scenarios, abbreviations are also ripe for misinterpretation, largely as a result of arbitrary or inconsistent uses of what is known as letter case, or more commonly as **grammatical case**.

The samples included here, for instance, use shorthand abbreviations that are in some sense universal healthcare abbreviations, presupposing that such a thing exists, and all represent deferrals to a consistent letter-case system. In the sample, abbreviations such as *Pt.* to denote *patient* use **title case**, whereby the first letter of the word is capitalized and the remaining letters of the word are written in lower case. Initials as abbreviations used to denote two or more words should then also use title case, such as *ER* to denote *emergency room*, and with the first letter of each word in the pairing being capitalized. Problems of clarification and context in shorthand entries and abbreviations tend to arise as a result of letter-case distinctions that fail to distinguish between one word, two or more words, or two or more words that are customarily compounded as one word (e.g., health care vs. health-care vs. healthcare).

Accepted shorthand notations include the common abbreviations (c/o = complaining of), the use of symbols (@ = at) or scientific terminology (O₂ = oxygen) and allow for clinical progress report entries to use the minimum space provided strategically.

TIME	FOCUS/PROBLEM	CLINICAL PROGRESS RECORD (Sign or Initial all Entries)
5/15	Chest Pain	Pt found in bed supine c/o chest discomfort. Head to toe assessment
5/18	O ₂	O ₂ via nasal cannula @ 3l/min applied
5/20	Chest pain	↑ chest discomfort 7.5/10 nitro spray sublingual chest pain reduced to 3/10 sublingual

TIME	CLINICAL PROGRESS RECORD (Sign or Initial all Entries)
0240	Sitting in chair 35yr old male facial lacerations & swelling. Odour of alcohol tox reported still not confirmed. Co-operative, pupils reactive and pinpoint. Pt. aggressive upon palp. of head & neck.
0810	pt placed supine in bed w/ ankle & wrist restraints.
0318	facial sutures to left occipital area x 9 & to left lower mandible x 6

Letter-case distinctions tend to form as a matter of habit through one's formal education, life experience, and native tongue, with issues of clarity often emerging when a healthcare practitioner—perhaps someone whose methods were learned or practised in a different setting or following a different linguistic register—defaults to instead using **sentence case** when abbreviating two or more words, or to using title case and sentence case indiscriminately and interchangeably.

Title case: The Patient Remains Unconscious in Recovery.

Sentence case: The patient remains unconscious in recovery.

Title case: The Chief's Grand Rounds Symposium on the Comorbidities of Eating Disorders

Sentence case: The chief's grand rounds Symposium on the comorbidities of eating disorders

Even when writing proper nouns that would normally always and without exception be written with capitalized first letters, a given healthcare writer's choice of case, at his sole discretion, prevails. In circumstances where sentence case is commonly used, such as library catalogues and in some journal titles, one might be surprised to find that specific names and locations, as well as other individuating words normally found using upper-case letters or written in title case revert to lower-case letters following the first word. Regardless of which case style is used, the general rule is that **prepositions** (on, in, at, etc.) and **articles** (the, a, an, etc.) are never capitalized, other than when appearing as the first word.

For example, while in the sample provided *Pt.* is an abbreviation in that it only refers to a single word—in this case, *patient* as a noun—title case is used to distinguish it from other markedly similar shorthands denoting one or more words, or any number of words that may use both a *p* and a *t*. This is where the proper and consistent use of letter case is key, in that referring to a patient *Pt.* in one circumstance necessitates that this same title-case system be rigorously followed, as later referring to the patient as *PT* may seem like a minor, negligible change, but could be cause for significant confusion and undermine the rationale of using shorthand in the first place. Abbreviations such as *PT* in a healthcare setting, especially when it marks a departure from an earlier shorthand entry, could denote two or more words (part-time) or even single words that are often abbreviated separately (physiotherapy), as well as an endless number of other interpretations. Such ambiguity could ultimately diminish efficiency, reduce care, expose practitioners to liability, and endanger patients.

Single-word action verbs, regardless of what type of letter case is used, are especially open to interpretation in that syntactically similar words with a similar number of consonants may be abbreviated in the same way, yet meaning fundamentally different things. In such cases, simple misunderstandings about what verb is being abbreviated can drastically change the course of care and can prove potentially catastrophic in certain clinical settings. For instance, *d/c*, *Dc*, *DC*, *D/c*, or some other combination of letters employing sentence case or title case could be—and have been—interpreted as *discontinue* in one hospital and *discharge*, meaning send a patient home, in another hospital. In some cases, abbreviations mean different things and stand in for different words in different wards or departments within a single hospital.

CHAPTER SUMMARY

By this point, you should be able to:

- Differentiate between the different types of rhetoric, as well as how they contribute to the development of the four rhetorical modes.
- Understand how both handwritten and electronic writings created in healthcare institutions are subject to public disclosure, and that no document or record is immune from being scrutinized by third parties.
- Discuss how the different English registers can exist simultaneously in the same piece of writing or in the same healthcare setting, and how this type of overlap might shape relationships between healthcare practitioners and their patients or clients.
- Define grammatical case, and understand how being able to differentiate between sentence case and title case is necessary in order to use clear abbreviations and initials when charting information.

Some self-check or class-discussion exercises you might want to try include the following:

- Research a particular medical ailment or condition along with its usual symptoms and treatments. Try writing a SOAP note documenting an interaction with a patient who presents at a healthcare institution with those same symptoms.
- In addition to the above, try writing a fuller and more detailed report using expository prose and using the inverted pyramid format; then, try reducing that same report by fifty per cent by editing for concision.
- Begin writing a register, or log, and make some notes every hour about a fictitious patient. Watch over the course of the day how your language changes or remains consistent. Ask yourself how your writing might change if other authors were contributing to this same ledger, how being a contributor to a healthcare anthology as

simple as a daily log might influence your own writing style, and how different styles might converge to create a consistent style of institutional prose.

- Look at the list of related FOI legislation and determine which one is used in your province/territory and what the governing act is called; also, do some additional research to see how people outside a healthcare institution might go about obtaining records that could ultimately lead to your being a “published” author.

Interpersonal Writing: Letters, Email, and Presentations

2

While the [previous chapter's](#) focus was primarily the more patient-oriented documents a healthcare practitioner might write on a day-to-day basis in her professional role, this chapter turns its attention to the concerns of workplace or business communication as they apply to healthcare settings. Hospitals, clinics, healthcare centres, health units—all are professional settings in which practitioners interact closely with each other and with other types of health and administrative professionals as part of a larger team. Particularly in the closely collaborative healthcare setting, the sorts of writing most commonly required for effective communication in the workplace—letters, email, text for presentations—are examples of [interpersonal communication](#). That is to say, they are examples of communication that occurs, either in person or through written media, between people with some knowledge of each other and with some sort of shared professional experience or desire to achieve a common goal.

Often, interpersonal communication is conceived of as strictly [dyadic communication](#): involving two people only. However, it is a term that can also refer to interactions within and between small groups. Interpersonal communication within a professional healthcare setting is sometimes referred to by the broad descriptor clinical communication, though that term can also have more specific applicability to patient-centred documents that pertain to healthcare delivery.

INFORMATION FLOW AND CHANNEL CHOICE

In [chapter 7](#), which looks at academic writing, we will discuss [prewriting](#): the process of figuring out just what is at stake, as well as to whom, in a given document. In the context of their workplace communication, healthcare practitioners should always strive to undertake a similar prewriting process of assessing the requirements of and expectations for any message they need to send, and the first considerations of such an assessment should be the direction (or flow) of their message and the choice of communication channel(s). The [flow of information](#) can be upward, downward, or horizontal in nature, and the operative direction in any communication situation will be determined by the purpose, subject, and sender of the message to be delivered.

In upward communication, information moves from subordinates to superiors in a professional setting—from, say, front-line practitioners to medical or even government administrators, or from staff nurses through the charge nurse to the nurse manager. The value of upward communication resides in how it is usually predicated upon those lower down the professional hierarchy being welcome and able to offer feedback and provide input regarding shared workplace issues. And that feedback will frequently come about as a direct response to something that was previously sent downward. In downward communication, those in positions of greater authority send messages down the line to their subordinates. Frequently, the sort of information that flows downward pertains to the things employees need to know in order to do their jobs: strategies, assignments, schedules, policy explanations. Lastly, horizontal (or lateral) communication occurs between those at more or less the same level within the workplace (or in the same department or

on the same floor, whatever sort of set-up fosters a sense of common professional experience and flattens any perceived hierarchical distinctions). Horizontal communication is, effectively, communication between peers, and it tends to be more informal in nature, often characterized by the use of casual or even intimate registers. By contrast, both upward and downward communication, cutting across hierarchical divisions as they do, will usually employ a formal register.

Having now given some consideration to the direction of the message you want to send, the next step in a prewriting assessment is to select an appropriate **channel** for that message. Channel refers to the medium through which a message is transmitted. Channels may be written or oral (such as a presentation, an in-person meeting, a phone call or videoconference), electronic or print, or some combination of these. To be an effective interpersonal communicator, you need always to match your channel to your purpose, and to do that, you might ask the following three questions.

What level of formality is appropriate?

The formality of your message (and thus of the channel required to send it) is in part a function of information flow. Are you sending the message upward or downward? Or are you sending it horizontally? If either of the first two directions (upward or downward), then something like an email, carefully written and proofread to ensure accuracy, would be an appropriate option. If you are sending your message horizontally, then perhaps an oral channel—a phone call or in-person conversation—would be best, or perhaps a more conversational-sounding email or a text message. The level of familiarity between sender and audience is likely to increase as the flow of communication moves from a vertical axis to a horizontal one. It is also likely that the perceived importance of a message will help to determine its channel. Written channels still generally seem more credible, and print documents are often more noteworthy for your audience than electronic ones. For internal communication (i.e., communication within a specific professional setting), however, written memos have been almost wholly supplanted by electronic correspondence, the most formal channel of which is a professional-sounding and well-constructed email.

How detailed or complex is my message?

It is likely but not necessarily the case that the complexity of a message will be commensurate with its formality. Written channels allow you more control over the organization of your message, since they allow for multiple drafts and revisions. Oral channels tend not to work as well for delivering a lot of technical detail with consistent clarity and/or exact language. Also, consider how dependent the message may be on contextual information or cues. It is perhaps necessary to support and enhance your description of something complex or technical by way of a visual aid. If so, a mixed channel of both discursive and visual elements is likely in order. And if your upward-flowing message speaks in part to tell your employers or team leaders about a negative experience—in response to a less than stellar performance appraisal, perhaps, or to a change in responsibilities or policies—it might then be important, formality aside, to consider employing a channel with some oral component. Such a channel choice can certainly enable you to tell your story in a manner that may better allow you to appeal to pathos through the use of intonation, body language, and facial expression, making it likelier that the message will resonate with the reader on a more personal, emotional level.

How quickly does my message need to be sent, and/or how quickly do I need a response?

Electronic channels afford the luxury of seemingly instant communication, as does an oral channel like a phone call or an in-person meeting. The abiding benefit of email from a reader's

perspective, however, is that it still allows for a response to be sent back that is thoughtful, coherent, and composed. The message receiver is not on the hook to offer something immediately and extemporaneously by way of response, as a phone or face-to-face conversation usually demands. Note that any sort of formalized response is likely at least in part to employ the same channel as the original message. If you choose to send an email, for example, you should expect to get an email back, unless you request otherwise.

AUDIENCE IDENTIFICATION

The other key consideration that helps to determine the most appropriate and effective channel to employ for your message is your audience. We have already touched on the importance of audience awareness in the [chapter 1](#) discussions of rhetoric and registers. As we will continue to explore in greater detail later on in the book, there is perhaps nothing that influences how and what you write more than your careful assessment of to whom it is you are writing. Who is your particular audience? An effective, productive answer to that question necessarily entails providing more than just the intended reader's name, title, or function within your healthcare team (or perhaps outside of it). To wit, ask yourself these things about your audience:

How is my audience going to react to the message I need to send? Is the message going to be received with resistance, or will it be accepted without issue?

Thinking about possible reader resistance before you draft may help you structure a written message in a way that is conducive to overcoming your reader's hesitation. Perhaps you can frame any negative material by way of a logical, credible-sounding explanation for it that precedes the actual negative bit, and attempts to rationalize and spin it more positively as something beneficial generally or to the reader specifically. Such a pattern of content organization is referred to as indirect. And if you are confident the reader will be receptive to your message, then you might think about organizing your material in a more direct way, getting right to the point without much preamble.

What does the audience know about my subject?

Never assume your audience will have the same knowledge of your subject as you do. Also, never assume in the case of an audience consisting of more than one person that the knowledge level will be uniform or consistent among members. How much detail should you include? What sort of technical language should you employ, if any? The problem is that, especially in the case of upward communication, too much superfluous detail in a message directed at an audience quite familiar with your subject may seem like needless hand-holding and come off as insulting or patronizing. Not enough detail, however, risks alienating your audience by not allowing them access to everything they need to know about your subject in order to understand your message, particularly any important terms and ideas.

How many potential audiences do I have?

We can draw a general distinction in professional communication between a primary and a secondary audience. **Primary audience** refers to the reader (more broadly, the receiver of the message) for whom the message is being constructed. **Secondary audience** refers to anyone else who might read or hear your message or who might be affected by its content.

Take, for example, a referral letter to another healthcare practitioner. The primary audience for that letter would be that practitioner himself. The secondary audience, however, could consist of anyone else in that practitioner's care team—administrative staff, nurses, perhaps colleagues

within the same clinical setting—who may want or need to see the relevant details of care outlined in the referral, in preparation for having to interact with the new patient in some capacity. Ultimately, the success of any message is predicated upon the primary audience receiving and acting on the information conveyed, whether by accepting it, refusing it, or by offering feedback or commentary. So when making your decision with respect to channel choice, message content, organization, and approach, it is the needs, expectations, and characteristics of the primary audience that you have to address.

In addition to thinking about audience in terms of primary and secondary readers (or listeners), you might also consider whether or not you have an initial and/or gatekeeper audience for your message. An **initial audience** is composed of anyone who will read your document or hear your presentation first, before it is delivered to the primary audience. They may offer comment on the content of your message or your choice of channel, and their comments may help you reshape your message or rethink your channel choice. In the end, however, your initial audience will not usually prevent your message from being passed along to its intended receivers.

A **gatekeeper**, on the other hand, has the power to keep the primary audience from ever getting your message; as a result, if and when there are gatekeepers in place, you need to assess them in the same sort of terms you apply to your primary audience, since they are integral to your success, defined as it is by your message reaching its intended target. Sometimes initial and gatekeeper audiences will be the same, other times not. If you are preparing notes or a script for a group presentation you are going to be doing with two other nurses, those co-presenters are likely to be indicative of both an initial audience (since they would presumably want and need to be the first people to look at your draft as it is supposed to articulate their ideas) and gatekeepers (since their dissatisfaction with what you have put together may prevent them from going forward with the presentation). In the referral letter example above, your initial audience (if there is one) may be anyone who proofreads or edits your letter. There probably will not be a gatekeeper, though in theory an administrative staff member working for the primary audience practitioner could delay his actually reading the referral by misplacing or withholding it. That staff member would thus be gatekeeper for a time at least, though not likely one of which you could be aware in preparing your letter.

TYPES OF INTERPERSONAL WRITING: LETTERS AND EMAIL

One of the conventional distinctions in professional communication often used to narrow channel choice and help determine document type (when the channel is a written one) is between internal and external. Is the message at issue being sent to an audience inside the workplace or outside it? In the business world, external communication still often takes place by way of formal letters, while internal communication—long the domain of the printed memo—mostly takes place now via electronic correspondence (i.e., email). As noted earlier, in healthcare settings particularly, email has taken over as the primary means of professional communication both internally and externally. However, there is still some call for letters in the form of referrals, references or recommendations, application letters, assessments in response to referrals, letters to employers of patients, letters accompanying patient transfers, and policy or general information letters for patients and/or other practitioners.

Letters

Though the specifics of content differ in each instance, there are important commonalities to note between all types of healthcare letters. Note first that any sort of external communication is necessarily an important public reflection of your (and your team's) professionalism and credibility, so cultivating ethos is essential. Use a formal tone but not an overly stiff or

unengaging one; provide all the information needed or required (per your assessment of the audience); and employ correct names, dates, and appropriate terminology wherever applicable. As well, ensure that your writing is both grammatically sound and correctly punctuated. Look ahead to [chapter 6](#) for the tools you need to do so.

In terms of expected formal components, note also that most letters sent from professional healthcare settings should have six parts:

1) Letterhead (or outside address)

Even the smallest healthcare practices are likely to have some sort of professional letterhead on which to print letters. Letterhead takes the place of an outside (return) address block, assuming it provides the sender's address, which it likely will. If it doesn't, an outside address block consisting of just two lines (address and street; city, province, and postal code) should go just below the heading, aligned with the left margin.

2) Date line

This is double spaced below either the bottom of the letterhead or the last line of the return address. The date should be written out fully (i.e., August 19, 2010).

3) Inside address block

At least double spaced below the date line (with perhaps as much as four spaces between), this block consists of three to five lines: recipient's name without any honorific (such as Dr., Mr., or Mrs.) but with professional designations and/or post-nominal letters (e.g., Aubrey Evans, MD CCFP); title or professional role, if applicable (e.g., Nurse Manager); company or organization name, if applicable; then address.

4) Salutation

Use "Dear" and the name of the recipient here, preceded by an appropriate honorific (i.e., Dear Dr. Evans). Punctuate the salutation with a colon.

5) Body

The body is single spaced throughout, with double spacing between paragraphs and no indents. Depending on the nature of the letter and the details of its content, the number of paragraphs will vary, but there will almost always be at least three, including a brief introduction that immediately orients the reader to your purpose in writing (not wholly unlike a thesis statement) and a brief conclusion. Letter paragraphing will always tend to be looser than paragraphing for reports or essays in terms of length. Letter paragraphs are often no more than seven or eight lines of text at the most, so concise, direct expression and the omission of any unnecessary details are key.

6) Close and signature

Most commonly, "Sincerely," "Yours sincerely," or "Yours truly" close out healthcare letters, punctuated with a comma. Following the close, leave at least four line spaces for your signature, then provide your name with any post-nominal letters, along with your title (if applicable). In the case of a letter being sent electronically as a PDF or otherwise, you can use a font that mimics handwriting for your signature, if you wish. There are hundreds of such fonts available for download, in addition to the standard MS Word fare such as Bella Donna, Freestyle Script, Kunstler Script, or Lucida Calligraphy.

Additional to these six standard components, some healthcare letters may also employ subject lines. When used, these should be double spaced up from the salutation. Depending on the nature of the letter it prefaces, the subject line frequently consists of a patient name or specific

healthcare topic (e.g., “Extended Ambulatory Care Clinic Hours” or “Revised Policy for Physiotherapy Assessment Referrals”) that anticipate the informative focus of the letter. The subject line sometimes begins with “Subject: ...” or “Re.” (meaning “regarding” or “in reference to”) and is not punctuated at the end.

Example: Block Style Letter Accompanying a Patient Transfer

Subject line here is patient's name followed by date of birth, listed in day-month-year order. The standard order for listing date of birth varies geographically, with DMY (as here), YMD, or MDY all being acceptable in Canada. The preference in the United States tends to be YMD or MDY. Note too that sometimes the patient's entire last name will be capitalized.

Brief concluding section is forward-looking; it anticipates future contact between sender and receiver. This is a common characteristic of closing paragraphs in professional communication.

Name and address of place of work aren't provided, as they are on the letterhead. Per her promise in the last paragraph, however, the writer here has included her phone number and email address.

Elgin-Middlesex Allied Healthcare Centre
1374 Upper Pinevalley Way
London, ON N5X 1Z1

October 23, 2014

Alice Morgan, RN
Nurse Manager
Shady Acres Retirement Village
Thunder Bay, ON N5P 3X7

Patient: Charles Theakston/D.O.B. 10-8-29

Dear Ms. Morgan:

Thank you for agreeing to take over care of Mr. Charles Theakston. As one of the nurses responsible for his care over the last eight weeks in the orthopedic unit, I am writing to inform you and your nursing staff of some of his personal and medical needs in the hopes of better facilitating his transition to your facility. Please refer to the patient chart for information not covered in this document.

Starting from one week after a right total hip replacement (THR), Mr. Theakston has received daily physiotherapy (PT) sessions consisting of minor stretching. Since his surgery, he has experienced a subnormal recovery time and has progressed slowly in meeting his weekly exercise targets. He has been told to limit the amount of weight placed on his right leg during walking exercises, an endeavour with which he struggles. His current exercise regimen consists of a 10-metre assisted walk three times daily. This has been in effect since October 19, 2014. He is encouraged to continue with this regimen until a new PT assessment can be done once he is settled at your facility.

Mr. Theakston has experienced several barriers in completing his daily PT regimen, and these have contributed to his subnormal recovery speed. Since his THR, he has reported mild disorientation ranging from two to six times a week. Symptoms typically include dizziness, slight confusion, and agitation. His disorientation typically lasts between three and eight hours. Blood sugar and electrolyte tests are usually performed during this time. To date, results have not indicated signs of hypoglycemia or dehydration; however, we recommend performing these tests during periods of disorientation to ensure blood sugar and electrolyte levels remain in the normal range.

The incision located on his right hip has been healing slowly but is almost completely closed. A 4x8 inch gauze pad has been the usual dressing material since the removal of staples on October 18, 2014. It is important to exercise caution when changing the dressing as the skin surrounding the incision site is sensitive and prone to tears.

As well, Mr. Theakston has demonstrated several indicators of depression, namely, decreased appetite, lethargy, irritability, and the occasional refusal of medication. These behaviours should be monitored to determine if intervention is necessary.

EMAHC will contact the patient transfer service to arrange Mr. Theakston's transfer. He will arrive at your facility on October 27, 2014. He has expressed excitement with regard to this transfer, and I hope it proceeds without major difficulty. My telephone and email information are below; please contact me if you have further questions.

Sincerely,
Alexa Buxton, RN
1-519-685-8500 ex. 54583
abuxton@emahc.on.ca

Address in letterhead removes any need for an outside (return) address block.

Internal address block: recipient name and post-nominal letters, no honorific.

Salutation: Honorific, name, colon.

Brief introductory paragraph announces the purpose and focus of the letter immediately and clearly.

In a fuller narrative account of symptoms and treatment such as in this letter, initialisms that will be used going forward are often written out in full upon first use.

This paragraph and the previous are the longest in the letter, at just seven lines of text. Note that 10-pt. font is employed throughout in order to keep the letter to a single page. While 12-pt is recommended, 10-pt is certainly still acceptable.

In terms of formatting details, note that all healthcare letters should follow the standard business block letter model. As the example above demonstrates, all parts of a block letter align with the left margin and all are single spaced, with double spacing (or more) between sections as outlined above. In general, keeping with the need for brevity and directness, letters should be kept to a single page, though the length and complexity of your subject matter may preclude that possibility.

Despite usually being directed more towards an internal audience, a workplace email should be no less formal than a letter, though you may be more familiar with the recipient on a personal level, especially if the email is an example of horizontal communication. Because we send email so regularly in our personal and professional lives, the distinction between casual and formal email is one that has become obscured for many. The difference between an email of the sort that you would send to a colleague to, say, organize a social function or to set up a lunch date and a professional email you would send to that same colleague regarding a work-related matter is quite significant and important to maintain.

As is the case for letters, there are certain formal expectations to which a professional email must conform that are not necessary for a casual email. For one, formal email will always have clear, directed subject lines. Most email programs will not let you send a message with no subject (at least without warning you first), but the nature and quality of the subject line is often of little or no importance in a casual context, particularly when your recipient knows you and is likely to read anything you send anyway. Like the subject line that may be used in some healthcare letters, the subject of a professional email needs to provide a clear and concise statement anticipating the content of the message body that follows. The sort of reader we need always to imagine in professional communication scenarios is busy and gets a lot of email in the course of a day. As such, an effective subject line should allow that reader to distinguish your message from other, less important ones, and to prioritize it accordingly. A good subject line will usually be four to seven words at most, though important details should not be omitted for the sake of keeping too strictly to that word limit.

Progress of Triage Efficiency Initiative

Changes to Patient Referral for Movement Disorders Clinic

Both of these examples present concise snapshots of what the ensuing messages will be dealing with, and they give some indication of purpose and tone as well. Both seem to be subject lines for informative, positive emails intended, in the first instance, to keep team members informed about an ongoing project of professional interest to them, and in the second instance, to explain or describe recently changed procedures regarding referrals for a specifically identified clinic. Both are also careful not to sound potentially negative by saying something like “Problems with Triage Efficiency Initiative” (even if negative progress is in fact what’s being discussed). Nor do they risk not piquing a reader’s interest sufficiently by saying something too generic or uninformative with respect to the particular focus of the email, such as “Patient Referral for Movement Disorders Clinic.” What about patient referral? Why should the reader need to know anything (more) about it? The success of an email message in reaching your primary audience can rely more than you might think on the effectiveness of your subject line.

Like letters, formal emails also need to have appropriate salutations at the outset. While “Hey” might work just fine for a friend, it is not appropriate for a work colleague (in a work-related message), a supervisor, or an employee further down the workplace hierarchy from you. Signal the formal tone of your email by employing a sufficiently formal greeting; follow the letter model of “Dear Dr. Evans,” or “Dear Ms. Jones,” and employ the same punctuation (a colon). In signing off, use a similarly formal and standard-sounding close (e.g., Sincerely, Yours Truly) and include your job title and professional distinctions in your standard email signature, as a matter of both precision and professionalism.

In terms of length, ensure that your email is brief—limited to one screen, where possible, and limited in its focus to a single subject. Again, keep in mind that hurried, overburdened reader. Email paragraphs tend to be even looser and shorter than letter paragraphs, though overall close

adherence to the conventions of grammar, correct punctuation, and appropriate, engaging style should be the same across workplace document types. Always, always take the time to proofread your emails before you send them.

TYPES OF INTERPERSONAL WRITING: PRESENTATIONS

Healthcare professionals and students alike will have frequent opportunities to engage with their colleagues, with patients, and with the broader public through informative presentations. Many of those presentations will involve working collaboratively as part of a team, whether in-person; online through FaceTime, Skype, or web conferencing programs; or via email or Google Docs as a way to get your content together and focused. Working effectively as part of a team involves figuring out what roles need to be performed in order for the presentation to reach its primary audience successfully, then ensuring that all of those roles are covered by your team members. Usually, each team member will have to take on more than one role, and sometimes several, depending on how many comprise the team (Salem-Wiseman & Zaman, 2015).

Often, roles will overlap with each other, and more than one team member will be working on accomplishing the same task. Who is going to do the research needed? Who is going to compile notes from that research into a workable, focused text to form the basis of the presentation? Who is going to frame that text as a script or set of functional talking points to prepare it for delivery? Who is going to proofread and edit those points? Who is going to put together audio/visual aids that enhance the presentation content without distracting the audience? Who is going to offer comment on the delivery of the material so that it can be fine-tuned as it is rehearsed? Who is going to do the actual presentation? Who is going to answer questions the audience may have? And who is going to be the team leader or captain? This last decision with respect to roles is an important one, as someone always needs to make the final decisions on things (informed by the input of the other team members). Perhaps the decision making will be delegated democratically to group consensus or majority. Either way, some framework for figuring out how decisions are going to be arrived at is absolutely crucial for the team to be able to get anything accomplished in a timely, efficient manner (Salem-Wiseman & Zaman, 2015).

Regardless of how labour gets divided among team members, or whether you are part of a team at all or working on your own, at the core of any successful presentation are an effective structure and a clear, engaging delivery. No matter how commanding and interesting a public speaker you or one of your team members may be, without a solid, coherent organization of the presentation's content, your audience will have a difficult time indeed following along. This is especially the case for a non-expert audience, which will likely require a more tightly focused (that is, necessarily more descriptive and explanatory) take on the subject at hand—one characterized by more frequent definition, perhaps, and greater attention to contextual framing. As with any type of communication, you must adapt your content and delivery to your audience. And usually, introducing any more than three to five main points or central ideas in the course of your presentation runs the risk of losing the attention and focus of any audience, expert or not.

Most presentations can be organized around a basic three-part structure that is not at all dissimilar to the general organization of an essay or report: introduction–body–conclusion. In the introduction, the goal is several things—to hook your audience and get them interested and to introduce your topic, state your purpose, and anticipate the content of your presentation to come. With respect to this last, you may give an overview of how you will proceed, and/or you may signpost for the audience some of your main points. One thing you definitely want to do right at the outset is introduce yourself to lend credibility to your presentation and establish authority. It is of the utmost importance that you make some effort to connect with your audience, and identifying yourself (as a fellow healthcare practitioner or a fellow student and/or as someone with the professional or educational credentials necessary to speak usefully on your subject) is a

way to help establish that you are worth listening to. With respect to the task of hooking the audience, you might want to begin with a question germane to a point you'll go on to develop. Doing so fosters immediate engagement and gets the audience involved and thinking. You could also try to strike a note of pathos by offering a sobering or surprising statistic or detail or an anecdote—personal or derived from your research. In any event, the goal should be to engage the audience and make them want to keep listening within the first two minutes of your talk.

The body is your opportunity to focus your topic in whatever way you want or need to. It is your opportunity to bring to bear all the research you have marshalled to the cause of establishing and thoroughly developing your main points. Keep in mind, however, the importance of providing context and description whenever you need to in framing your topic for the audience. If any point you make or information you provide isn't self-explanatory, you need to explain it; that includes carefully defining important terminology. Also, don't simply enumerate facts. Analyze, interpret, and explain those facts to your audience with a view to the bigger picture of your presentation's focus and point, just as you would do in the body of an essay or report. Make sure as well that your audience knows what your main points are, so they can trace the logical movement of your discussion. Effective use of visual aids, something we will talk about in more detail below, can help with the important task of distilling things down to a more easily digested point form for the audience to follow along.

As for the conclusion, be brief but summative. What do you most want the audience to remember about or take away from your presentation? What is the significance of the points you made? Is there something important you can leave the audience to think about by asking them a question? If you can bring your conclusion back to a question, statistic, or anecdote with which you began, it is often a rhetorically sound thing to do, as it lends circularity and a clearer sense of closure to your presentation. Be sure as well to give your audience the opportunity to respond to your presentation at the end of your conclusion by opening up for questions.

The thing to remember is that your conclusion is important, and though it may be brief, it should not get short shrift, nor should it be omitted. In fact, if you find yourself running long and need to wrap things up before you have gotten through all of your material, rather than hurriedly finishing up the body and ditching your conclusion, you should actually (and perhaps counterintuitively, we recognize) skip ahead to the conclusion and make sure you take advantage of the opportunity it provides to summarize and reflect. The backward-looking nature of a presentation's close as well as the opportunity to ask questions of you directly is crucial in helping the audience remember, reconsider, and consolidate the preceding content.

A well-structured and tightly focused approach to your subject is just half the equation, however. Effective delivery is the other. Here are some of the keys to ensuring that how you deliver your presentation doesn't undermine the quality of your content and organization.

1) Try not to read from your notes.

In order to be engaging, you need to be looking at your audience regularly, something you are prevented from doing if your eyes are cast down to your talking points all the time.

One way to avoid the temptation to read is not to write out a script of everything you want to say. Keep your notes sparse. That said, for many public speakers there is comfort in having a more complete set of notes to fall back on in a worst-case scenario of freezing up or drawing a blank. In that case, print your notes off in a large font (at least 14 point), and if there is a podium available, use it to set your notes on, then stand back from the podium far enough that you can still read your notes but no longer have to look down to do so. This gives some illusion of maintaining eye contact with the audience. Ultimately, the best way to keep from having to read directly from your notes is to practise delivering your presentation until you develop a very clear sense of what to say and how to say it. Don't, however, memorize your notes; sounding like you are speaking naturally is key to

building and maintaining rapport with your listeners. Being confident that you always know what to say next during a presentation is also a good way to help lessen or eliminate any reliance on vocal space fillers such as “umm” or “okay” or “like ...” or “right?”

2) Be aware of your pace.

Don't speak too fast, though this is something much easier said than done if you tend to get nervous in front of an audience. The more you have practised, and thus the more confident you are in your content, the less likely it is that you will be overly nervous (so the more likely it is that you will be able to control your pacing). Still, breathe deeply and slowly prior to presenting, and try to begin your presentation by speaking as slowly as you can; you will invariably start speeding up as you move along.

3) Think about the impact and importance of non-verbal communication.

Non-verbal communication refers to a variety of things—body language, vocal qualities, eye contact—that can either help to enhance your presentation and your audience's experience of it or work to undermine its clarity and effectiveness. It helps to look like an authoritative, credible presenter by not fidgeting, and by standing tall and confidently moving around the front of the room, always maintaining as much eye contact as possible with your audience. Employ gestures when they are emphatic and natural-seeming. While it can be distracting to do all your talking with your hands, it can look stilted and unnatural to stand there with your hands behind your back, in your pockets, or clutching your notes. Appropriate facial expressions can also help to draw in and engage your audience, as can varying the intonation, volume, and intensity of your voice as it suits your material. It should also go without saying to dress comfortably but professionally; look the part of someone whose words and ideas warrant attention.

4) Employ visual aids in useful ways.

Think about how to ensure your visuals will have maximum rhetorical impact. One way is to limit your use of them; don't allow them to take over your presentation and replace you as the primary source of information. Always, they should enhance, not distract. If you are using presentation software such as PowerPoint or Prezi, keep the amount of information on each slide limited, avoiding undue clutter and keeping things clean and readable. As a general rule, include no more than two illustrations or five to six points on any slide—no more than seven lines of text total—and where possible, make your bulleted or numbered points grammatically parallel in construction. See [chapter 6](#) for more details on using [parallelism](#) as a way to emphasize conceptual or thematic similarity.

Use at least a 16-point font for the text on your slides, and employ titles that indicate the nature of the information provided. Titles should always be bolded, in a sans-serif font such as Arial. Your body text, on the other hand, may use a serif font (such as Times New Roman) as the serifs or ticks—the ascenders and descenders coming from the tops and bottoms of each letter and leading into the next—can facilitate ease of reading in larger blocks of text because they help lead the eye more quickly from one letter and word to another. Use fonts consistently throughout your presentation to establish recognizable, meaningful patterns. Use the same font face and size for all titles, the same for all body text, the same style of bullets and type of numbering. Make sure too that your slides are high contrast with respect to colour choices. In dark rooms, use dark background and light text, and use light background with dark text in lighter rooms. All told, limit your use of colours to four (Locker & Findlay, 2012; Meyer, 2010).

APA Documentation: The Basics

The American Psychological Association (APA) style is frequently employed in Health Science disciplines (e.g., Nursing)

It uses parenthetical in-text citations that provide info keyed to an alphabetized list of source citations included at the end of the essay.

(For APA, it is called "References." For MLA style, "Works Cited.")

Title here is 32 point Tahoma, body is 24. Note parallel construction of body section, short sentences throughout. And while the slide just exceeds a suggested seven-line limit, the text is limited and separated with sufficient negative space to be wholly readable. Note too the use of contrast: white text on dark grey background.

Don't put your visual up on the screen until you are ready to discuss it, and make a note to give your audience a chance to look it over thoroughly, particularly if it contains a graph or chart. Interpret and carefully explain any such visual depiction of data for the audience, and in general remember always to comment on what you have on screen. However, just as you shouldn't read directly from your notes if you can avoid it, don't ever read directly from the screen either, as doing so turns you away from the audience and thus negatively affects volume, clarity, and authority.

CHAPTER SUMMARY

By this point, you should be able to:

- Understand and define both professional and interpersonal communication as those terms apply to healthcare settings, and describe the three ways in which information can flow within a workplace.
- Recognize the difference between various communication channels, understand the fundamental importance of channel choice during the prewriting phase, and ask

questions that can help you fit your channel to both your message and your audience. You should also be able to identify the various types and levels of audiences you might encounter in a professional communication context.

- Recognize the difference between internal and external communication and between the channels conventionally associated with each: letters and email. You should know the six components of a formal healthcare letter as well as the expectations of block-style formatting. You should also recognize the characteristics of and expectations for a formal (as opposed to casual) email and know what constitutes an effective subject line.
- Think productively about the essential elements of an effective oral presentation, whether as part of a team or on your own, with respect to both organization and delivery.

Some self-check or class discussion exercises you might want to try include the following:

- Consider the various sorts of channels you could employ to send a message in a workplace setting: written/oral, formal/informal, print/electronic. Brainstorm and record as exhaustive a list as you can of the relative merits and shortcomings of each. What kinds of messages would work best with each? For what kinds of readers would each one be most appropriate?
- Go back over some personal, casual emails you have sent (and/or received). Pick some to re-cast as formal correspondence suitable to the workplace. What do you need to do to revise them? Is tone an issue? If so, just what about the writing is making the tone inappropriate to a more formal context? What about salutations and/or subject lines?
- Assess yourself as a public speaker. First, make a list of all of the things you aren't sure you do well, or the characteristics you see yourself as having that aren't necessarily conducive to being an effective presenter. Next, make a similar list of all of the things you do well or the positive traits you possess that might counter or cancel out the negatives. Then, prepare a very short, two- to five-minute talk based on some aspect of a paper you have written recently or one you are working on now. You could also make that talk a response to an online article concerning a contemporary healthcare topic. As you develop and deliver that presentation—to yourself or to a small audience of friends or family—the point is to use the lists you made initially as a guide. Focus on the positive things you've identified about yourself as a speaker, and learn to gain confidence from them. As for the negative things, try picking one or two and using the presentation exercise as an opportunity to start working through and improving upon them, or at least to start thinking about ways you might do so.
- Prepare a very brief PowerPoint or Prezi slideshow to accompany a presentation on the same topic as above. Be very mindful of the nature and length of the text on each slide and of using titles effectively throughout.

PART II

Narratives in Healthcare

Narrative Medicine, Parallel Charting, and Portfolio Writing

3

Having a command of expository prose and the ability to communicate clearly and effectively in healthcare are key competencies among medical practitioners and are highly sought-after skills; yet both institutional and interpersonal writing in the context of public medicine are comparatively recent areas of scholarship and teaching. During its relatively brief lifespan, the development of institutional prose as part of a healthcare practitioner's complete education and toolkit of skills has also spawned a number of new areas of writing. In brief, it has managed to generate a great deal of discussion both inside and outside healthcare about what the future role of writing, communications, and the humanities disciplines in the context of healthcare might look like.

For example, a good deal of this new movement in healthcare writing involves the composition of works that transcend traditional institutional models to take on more personal, reflective dimensions. As is explored in this chapter, it is not only writing but also reading in healthcare that are fast becoming areas of communication seen as increasingly pivotal to professional performance. This is a shift in thinking that in part reflects changing models of healthcare delivery, as well as restructuring of healthcare education, training, and staffing. In fact, one might argue that healthcare writing has rather quickly evolved to become one of the more dynamic and changeable areas of writing, rhetoric, and communication generally, and is in fact breaking new ground by uniting disciplines that until recently were thought to be at odds with each other. While these types of great changes often bring with them great expectations, it should be noted that healthcare writing, like reading, is becoming increasingly popular among practitioners, academics, and even the general public, which has a vested interest in the future of healthcare delivery.

As discussed in [chapter 1](#), exposition tends to be the dominant form of written prose—or the most commonly recurring rhetorical mode—seen in institutional settings, including the day-to-day activities of healthcare professionals operating in various care-delivery environments. That said, other rhetorical modes are nonetheless found to emerge when examining closely affiliated forms of communication created by healthcare professionals—writing activities that do not necessarily make their way into official patient charts or records, but which can prove equally valuable in terms of ensuring a holistic and systematic matrix of care. Exposition is certainly the most effective and reliable method of documenting information during the course of a healthcare professional's primary duties within a care-delivery environment, but rhetorical modes such as description and narration also play key roles in other forms of healthcare writing that are carried out behind the scenes, yet which many professionals now argue are just as important. These are forms of writing that, contrary to charts and EMRs, amount to the intellectual property of the author rather than the healthcare institution, but which can still serve to improve patient care. These forms of writing are now also thought by many to significantly improve clinical performance, bedside manner, professional satisfaction, and even the emotional well-being of healthcare providers themselves; the idea is that writing in service to the patient record or the

operational requirements of a healthcare institution only covers a small fraction of the information that can and should be documented. The authorship of discretionary or supplemental information that goes beyond the basic exposition found in institutional prose can be generally described as falling into a broad category of writing, reading, and critical thought known as **narrative medicine**.

It should be immediately noted that narrative medicine is a very intricate, advanced, and ever-expanding area of scholarship, discussion, and practice that exceeds the scope of this book as an introductory text on healthcare writing. However, this chapter offers a basic introduction to and history of some of the key tenets of narrative medicine complete with examples, so that readers can understand how healthcare writing functions as a continuum that goes well beyond the initial patient–clinician encounter and even the types of interpersonal communication discussed in [chapter 2](#). With that in mind, this chapter on narrative medicine and its representative documents will also expand a discussion raised in [chapter 1](#) with respect to how healthcare professionals are all to some extent authors in earnest—perhaps not so much professional writers as professionals who write—whether or not they conceive of themselves as such. The comparatively new and ever-expanding interest in narrative medicine also reflects the fact that, because healthcare professionals are otherwise engaged in so much institutional writing of a potentially public nature, they in many cases develop an appreciation for writing using other rhetorical modes, and creating texts of a comparatively private, anecdotal, and reflective nature versus a purely clinical and expository one.

As a matter of context, narrative medicine does not conform to a specific narrative structure, and in terms of the applicable rhetorical modes, it could be most accurately described as being a hybrid of both description and narration rather than the more institutional mode of exposition. Narrative medicine incorporates elements of journal and diary writing as well as espousing anecdotal, biographical, and autobiographical content. At the same time, there are some residual expository elements that remain as holdovers from the institutional writing that serves as the original foundation of narrative medicine; this is in part because the “medicine” in narrative medicine and the clinical orientation of the writing tends to be preserved as the prose moves from the care-delivery environment to the personal voice of the author. In other words, narrative medicine, while narrative-based as the name suggests and while comparatively liberal, creative, and reflective in terms of its style, is ultimately still about the practice of medicine.

In spite of increasing publicity, education, and advocacy, narrative medicine remains a comparatively esoteric area of healthcare writing and is far from a unified field of study; it is one that is still what might be described as underappreciated, remaining in its adolescence for some time now—arguably for too long. Narrative medicine is widely understood to have emerged, or at least received academic and clinical accreditation, at Columbia University in 2000, where a master of science program in the field, and one targeted at existing healthcare professionals, was launched by a core group of interdisciplinary faculty responding to something of a crisis in Western healthcare. Led by its current leading advocate and author of record, Dr. Rita Charon, narrative medicine arose in part as an academic-clinical movement that objected to what its Ivy League pioneers saw as a transactional, fast-food approach to clinician–patient interactions across Canada and the United States in particular. This included the increasingly commodified and corporate-minded micromanagement of practitioners’ writing practices, and an industrialized model of patient care in a more general sense. Narrative medicine was thus conceived from what was then a fledgling discipline known as literature-and-medicine. It was an experimental field that was much more theoretical than practical, but was one that served as the foundation upon which narrative medicine was ultimately built (Charon, 2008, p. 4). In building on that foundation, narrative medicine has since emerged as a multidisciplinary tradition that engages both practical and theoretical applications, and one that is fundamentally concerned with how healthcare writing can be used to modernize and humanize medicine.

In their collective bid to rescue healthcare writing and communications from the margins of professional discourse and elevate it to something of its own literary genre—one that transcends the practice of medicine as traditionally understood—the early adopters of the narrative medicine model sought to draw on the writing practices and cultures of other disciplines. In doing so, they also sought to reorientate healthcare as an interactive and introspective field focused primarily on well-being rather than corporate efficiency at the expense of patient care. In fact, the creative origins of narrative medicine, while today being chiefly affiliated with Charon and the graduate program at Columbia, date to a seminal anthology titled *Narrative Based Medicine* (Greenlagh and Hurwitz, 1999) that was first published in the United Kingdom. Authored by an array of widely respected scholars traversing a number of disciplines, including renowned paleontologist and evolutionary scientist Stephen Jay Gould, this would appear to have been the first recognition, at least in terms of scholarly writing, of the future importance of narrative medicine across the whole of healthcare.

A generation or so later, the rationale for leading universities offering a focused course of study in narrative medicine, aside from its interpersonal and literary restorative value with respect to patient care, is that it also translates into improved job satisfaction among healthcare practitioners. While these types of ideological hypotheses about the practical value of a narrative-based approach to medicine are difficult to quantify in a statistically based and efficiency-oriented healthcare setting, the qualitative evidence of its effectiveness—as extolled in various academic programs, hospital symposia, and scholarly publications—collectively suggests that this is soon to become an expected competency and practice of all healthcare professionals.

Designed to be applicable to the work done by every healthcare professional in every facet of healthcare as broadly defined, narrative medicine also engages academics and writers in myriad other fields, including English, literary studies, history, criminology, theology, and the humanities generally. This convergence is why narrative medicine epitomizes new and emerging trends in scholarship and communication that are **multidisciplinary** in nature. As the name suggests, this means that multiple disciplines or areas of study come together for the purpose of finding a common solution to an issue that concerns several fields at once.

Multidisciplinarity in narrative medicine is therefore defined by the fact that it recognizes medicine as being more than just anatomy, physiology, and pathology and—while still respecting these core components—engages more ethereal concepts that defy conventional charting. This engagement includes investigating metaphysical and spiritual concepts and their role in holistic wellness and systematic health, including the relationship between not only a patient and her caregiver, but also a patient's relationship to her own emotions, her own body, her friends and loved ones, and her acceptance—or denial—of her own mortality. Conversely, narrative medicine recognizes that certain patients will elicit emotional and spiritual responses in clinicians and healthcare practitioners that gravitate towards the personal rather than the strictly professional, and that certain medical cases, without a creative, descriptive outlet, may be problematic for practitioners.

The idea that descriptive prose and storytelling, specifically the act of composing narratives separate from the official record, can translate into improved patient care and professional performance is not without its sceptics; however, narrative medicine, by the nature of its guiding principles, has also excavated new discussions and ways of engaging timeless topics in healthcare communication that are of interest to all practitioners, whether proponents of narrative medicine or not. Such topics include questions encompassing what happened to the baseline healthcare communicative competencies—a clarity and honesty of exchange that used to exist between patient and practitioner, but which seems to have since been lost to history. The most obvious of these competencies as it relates to narrative medicine is what is known as **attentive listening**, with the price for the tremendous clinical and technological advances made in medicine in recent years being an increasingly impersonal and assembly-line standard of care where little to no

dialogue can be established (Charon, 2008, p. 4). Narrative medicine is therefore seen as a restorative movement, a vehicle for “humanizing medicine” (p. 8) and returning it to its roots through the art of prose as its creative engine.

The one element of narrative medicine that goes beyond the actual craft of writing—yet which also enables it—is attentive listening. Attentive listening also requires that the listener, or the healthcare practitioner, not only listen to and absorb the words being spoken but also absorb the full spectrum of the patient’s communication, verbal and nonverbal alike. This includes the tone, tenor, and speed of the words being spoken (paralanguage), as well as variables like body language, eye movement, facial expressions, and any other factors that can contribute to understanding the patient’s full range of emotions. In other words, narrative medicine can theoretically equate to an improved bedside manner as the healthcare practitioner, in developing narrative content and approaching the patient encounter as a storytelling exercise through attentive listening, is then able to acquire additional details about a patient’s condition, background, or state of mind as part of a personal story. These are of course details that might otherwise be lost or omitted during routine or expedited interviews that force the patient to edit what he shares in a purely institutional context.

Healthcare practitioners may in fact be surprised to note what additional details are disclosed by patients when they simply wait and allow patients to pause and then resume their monologue in their own time; this is the first step in attentive listening and it requires that practitioners allow patients to control the speed, direction, and flow of the conversation without forced edits. Many patients, even routine users of the healthcare system or those who have developed prolonged professional relationships with their physicians, home-care nurses, therapists, dentists, or any type of healthcare provider, are not surprisingly often intimidated during interviews or assessment and may be reluctant to make self-disclosures. It is therefore imperative that practitioners take the time to critically absorb all dimensions of a patient’s narrative, and allow the patient to self-edit with the understanding that the process is more confession than interrogation.

Actively absorbing and reflecting upon the confessionals of patients who are struggling with an illness, coping with a chronic condition, or facing challenges—whether physical, emotional, or spiritual—as a result of a disability, or chronic or palliative condition, lies at the heart of attentive listening. In terms of how attentive listening then goes on to inform a system of narrative medicine, it involves listening to patients not just as subjects to be treated or managed but as stakeholders in a public system with their own evolving narrative histories. In the context of patient care, a narrative can be described as any chronology, summary, or confessional that features “a teller, a listener, a time course, a plot, and a point” (Charon, 2008, p. 4). Narrative medicine in turn necessitates two or more participants, and relies on a relationship of full and unbiased disclosure that requires looking beyond conventional medical practice and drawing on the methodologies of other professions that are themselves shaped principally by such disclosures, as well as interactive dialogue and narrative.

From anthropological fieldwork where researchers and ethnographers embed themselves among an identifiable population to elicit oral histories and observe everyday customs, to the work done by penologists in prisons, thanatologists in grief counselling groups, reporters when documenting eyewitness testimonies, and both clergymen and detectives alike when receiving confessions, all of these professional interactions engage forms of attentive listening that require two things. First, they require more listening than talking (generally an 80/20 rule); and second, they ultimately translate into detailed, written records that reflect the experience of the interaction, including what the interviewer took away from the interview as much as the technical content yielded from the interaction itself. Building on the documented successes of what is known as narratology, or how the value of storytelling can advance scientific or fact-based methods of enquiry, is just one example of how narrative medicine is the paragon of the

multidisciplinary model, and how it draws on the existing and best practices of other disciplines. These are typically disciplines that have comparatively similar—but also distinct—experiences with personal interviews, and where these interviews inform larger narratives that have immediate consequences on everything from physical health to public policy. Like these other disciplines, narrative medicine is also informed by practitioners being regular—and critical—readers as much as they are writers.

CRITICAL READING AND HEALTHCARE NARRATIVES

A core component of existing and emerging graduate programs in narrative medicine is not just writing, as one would expect, but also reading. Being a regular reader is one of the most effective methods through which those aspiring to improve their writing can gain insight into the craft, regardless of the genre. While healthcare professionals are frequently required to read discipline-specific material or technical data during the course of their formal education and their clinical duties and obligations, as well as in relation to their ongoing professional development—peer-reviewed journals, health-related news features, and even works of non-fiction encompassing issues of professional relevance—narrative medicine advocates and to some extent necessitates regular and critical readership of works that might not normally be considered relevant to the practice of medicine.

The “critical” in critical reading is not so much a matter of criticism as much as it is a matter of being analytical and looking beyond the surface structure of what is being presented. Another term used interchangeably with critical reading is close reading, which can be distinguished from its opposite, casual reading. Even detailed and dense texts read out of obligation can impart casual reading, in that casual in this context merely implies that the reading process itself is to some extent superficial and intended for the purposes of learning or memorizing essential facts where little interpretation or independent thought is required. Conversely, close reading, as a synonym for critical reading, requires balancing “intellect, concentration, imagination, metaphorical thinking, and moral confrontation” while navigating a given text (Charon, 2008, p. 125).

Curricula in narrative medicine are therefore becoming increasingly receptive to a wide array of texts that represent any number of topics, and all of which as a rule require critical or close reading. The idea in doing so is that practitioners can draw on content that is not explicitly medical in scope in order to become better caregivers, not unlike the way that narrative medicine can look to role models outside healthcare for best practices in interviewing. Beyond merely appreciating the value of literature, narrative medicine programs, as well as medical schools, nursing programs, and health sciences curricula, are now also frequently offering reading groups that incorporate interpretive texts that require analysis and metaphorical thought in addition to conventional textbooks. As these groups, and in some cases classes created to accompany such groups, explore literary titles that celebrate the multidisciplinary purview of narrative medicine, students and practitioners alike learn how critical reading can help bridge the communicative gaps between practitioner and patient, as well as enable acute care and holistic well-being. In the arts and humanities, this type of interdisciplinary discussion about the way that texts complement each other has for generations been referred to as comparative literature.

Comparative literature is in many respects a difficult area of scholarship to define, or at least contain to a single definition. However, its applicability to healthcare writing and communication is becoming increasingly self-evident, as seen in the popularization of narrative medicine. Critical reading and comparative literature are in fact the mechanisms through which increased value is being placed on fictional texts that represent different periods in the history of medicine, including how healthcare providers are depicted in texts written both in English and other languages. In brief, in much the same way that groups like the pioneering Doctors Without

Borders (originally *Médecins Sans Frontières*) has made great strides in adopting a world-centric, non-partisan approach to enabling universal healthcare as an unencumbered right, comparative literature has been referred to as literature without borders; it has similarly espoused a terrestrial rather than territorial approach to the study of texts. The expanded perspective includes the critical reading of books spanning multiple languages and generations but that speak to common themes—topics that can be considered universal in their relevance. Given its scope and scale, comparative literature in healthcare naturally includes a similarly open-minded approach to understanding what texts are deemed relevant and valuable to the study of medicine, regardless of when they were first written. Narrative medicine and the current scholarship in comparative literature both espouse a global, all-inclusive approach to stories, which makes them nicely paired.

While comparative literature has historically focused on examining and finding commonalities between the written traditions of specific nations, the current movement has been toward critically examining works represented by cultural systems rather than countries, and texts representing specific language traditions regardless of where they were actually written. Given the manner in which the current knowledge-based economy reflects new trends in global travel and employment, this simply makes good sense, and also removes any unnecessary political or nationalistic distractions that might compromise an unbiased analysis and critical reading. In terms of narrative medicine and what specific literary works can offer the practice of medicine, comparative literature is really the ideal lens through which to examine texts, of various mediums, in the context of patient care. Books, journals, essays, editorials, and even music, film, and graphic art can all be used as “texts” in the broadest sense to assist in developing healthcare communication skills. A work of Renaissance prose fiction, for instance, is a text constituting a sample of representative literature from one cultural and language tradition that can be compared to and blended with the culture and language of healthcare as another tradition, regardless of nation of origin.

Critical reading in healthcare as part of the narrative medicine paradigm is therefore not a linear process. It is not a proscriptive system that unfolds the way that one might read technical information, commit it to memory, and then apply it—whether in theory or in practice—in the care-delivery environment. Critical reading in healthcare, like in the types of reading groups and symposia found at Columbia University where narrative medicine was first conceived in earnest, is a much more abstract, experiential, and self-reflective exercise. For these reasons, it may sometimes lead sceptics to question what the tangible benefits of critically reading a given text are to their medical expertise—and that is precisely the point of it. Such questions are also in part why critical reading in narrative medicine is enhanced by group discussion, debate, and seminar work, and where the lessons drawn from such texts can be fleshed out through collegial banter and discourse.

Take for instance the following four texts, all of which offer healthcare professionals some valuable lessons and all of which require a critical reading in order to assess their true contributions to narrative medicine.

Title: *Mysteries of Udolpho*

Author: Ann Radcliffe

Original Language: English

Year Published: 1794

Country of Publication: England

Synopsis: Generally considered an iconic work in the Gothic literary tradition, the narrative depicts a young girl named Emily on an odyssey of nature through the Pyrenees mountains following the death of her mother from illness. The girl is in the company of her widowed father, whose personal finances and health are in mutual and rapid decline. During the journey, Emily meets and falls in love with a mysterious man known only as Valancourt. Following the death of her father, the now orphaned Emily is sent to live with her loveless aunt, whose new husband tries to thwart her growing love for Valancourt. When she objects, she is imprisoned in the crumbling Castle Udolpho, where she is witness to apparent supernatural activity. Her experiences there ultimately allow her to uncover a great deal of information about her family's history, herself, and life generally. Whether the apparitions and hauntings that Emily witnesses in the castle are genuine, or are hallucinations caused by the environment and her isolation—or some other scientific explanation—is never fully explained and, in the end, is immaterial to the truths she finds.

Title: *Fathers and Sons (Otcy I deti)*

Author: Ivan Turgenev

Original Language: Russian

Year Published: 1862

Country of Publication: Russia

Synopsis: A young medical student named Arkady graduates from the University of St. Petersburg and returns to his rural home with a friend in tow named Yevgeny. The men met at university, where they adopted the philosophy of nihilism—a disbelief in anything and a rejection of conventional values and the idea that life can have purpose. Arkady's new views seemingly put him at odds with his medical vows and obligations, and his relationship with his father becomes strained. He and Yevgeny consequently leave to travel to a nearby province, where they both meet and fall in love with an older widowed socialite named Anna. Because love is one of the main forces rejected by nihilists, Anna's power over both men breaks their common bond and they begin to drift apart, particularly after Yevgeny makes a leap of faith and professes his love to Anna but is rejected. As both men continue on their trek, Arkady and Yevgeny have an inevitable falling out and go their separate ways while encountering various setbacks and challenges on their own. While Arkady finds love and becomes engaged, Yevgeny never gets over his being rejected by Anna and losing Arkady as a friend in the process. His self-doubt ultimately leads to carelessness in his medical practice and, one day while conducting an autopsy, he cuts himself and acquires a typhus infection. Anna visits him on his deathbed so he can find solace in seeing her face a final time, but he ultimately dies alone and unmourned.

Title: *In Search of Lost Time (À la recherche du temps perdu)*

Author: Marcel Proust

Original Language: French

Year Published: 1913–27

Country of Publication: France

Synopsis: Published in seven volumes over a fourteen-year period, this epic story is likely Proust's best-known work, is widely cited as the stylistic foundation of the modern novel, and is routinely praised as one of the best fictional works of the twentieth century. Its legacy can also be found in any number of contemporary commercial media, including any ensemble cast television production (situation comedies, soap operas, hospital dramas) where the focus is less on a specific plot as much as an overview of interweaving experiences and relationships between characters. As told from the perspective of a first-person, unnamed male narrator, the seven complete volumes represent a coming-of-age story, and chronicle the narrator's growing into a man, becoming an active citizen and finding his place in society, falling in love, being betrayed, making enemies and rivals, and ultimately finding himself through his love of writing. More importantly, the novel chronicles the narrator's life as a search—a search for meaning, purpose, and learning. Drawing heavily on the narrator's involuntary memories, the story intimates that our memories should serve not as routes of reference to the past or as sentimental and nostalgic devices as much as roadmaps to lead us to finding our purpose in life. The novel is extremely thematic and symbolic and has not surprisingly been dissected at length by critics, philosophers, and historians; however, the ending and its lessons are quite clear. In his realization that life is a journey, and that events and people intersect to become part of each person's story, time becomes not something that is lost but gained. As part of his realization, the narrator, in the twilight of his life, puts pen to paper and begins chronicling his journey through the world with the insight only age and wisdom can provide.

Title: *The Road*

Author: Cormac McCarthy

Original Language: English

Year Published: 2006

Country of Publication: United States

Synopsis: In this Pulitzer Prize-winning novel now considered a key environmental text, the narrative follows a nameless father and son as they push a rusted shopping cart full of their meagre belongings south toward the coast in a post-apocalyptic America replete with unspeakable cruelty and desperation. It is unclear what exactly caused the world-ending cataclysm, and in the end it has no bearing on the story as it is told. The boy's mother—having resigned herself to a horrific future amidst a dying planet immersed in what seems to be a volcanic winter—gave up hope and committed suicide sometime before the story begins. In doing so, she left father and son on their own to scavenge for food and avoid the roving bands of cannibals and thieves who make up most of the remaining human survivors. As the two make their way toward what they hope is a warmer climate, the father realizes that he is dying from an unknown illness, but carries on for the sake of the boy, home schooling him on the road and teaching literacy, morality, and history wherever they are able to make camp. Upon reaching their destination, they find nothing but further lawlessness and despair, and the father ultimately succumbs to his illness. The boy holds wake over his father's body for several days until another family—apparently the only other noble people left alive—find him and take him in to continue roaming the land in search of salvation.

Four novels published over a two-hundred-year period, in four different countries, three different languages, and for very different audiences: all of these texts are representative of how comparative literature connects different cultural and literary groups through common moral, intellectual, or philosophical themes. In all four novels, one also finds that despite being separated by centuries and distinct writing traditions, the stories share mutual lessons that connect to broader issues in healthcare, as they have always existed. Despite their different settings, characters, languages, and storylines, the novels ultimately incorporate themes of illness, isolation, mortality, morality, purpose, fear, love, loss, beauty, decay, memory, redemption, and the importance of personal quests. Beyond the pages of these novels, these are all very real issues that both healthcare providers and patients will mutually confront during, for instance, palliative or critical care, or in any ward environment for that matter. Even a simple visit to a general practitioner, depending on what information is being disclosed or delivered, can elicit a torrent of emotions or feelings that conjure these same themes. Just as Radcliffe leaves the reader to ponder whether the apparent supernatural occurrences in *Castle Udolpho* are genuine acts of the uncanny and unexplained, or can instead be assigned some rational explanation, so too will healthcare practitioners often be required to explain events that defy clinical logic and rationality to patients who are either in disbelief, or who want to believe in something more. Similarly, in *The Road*, readers are left to question the purpose of the father teaching the boy about the past and the value of academics when there is no future, knowing there will never be any practical use for the knowledge, and that what remains of humanity will likely only survive another few years. These same moral and logical questions of “why bother?” are at the heart of holistic care, including the struggles patients may encounter in finding purpose in maintaining a routine or completing day-to-day tasks in spite of their apparent long-term irrelevance—signifiers of despair that healthcare providers may also be faced with.

These four novels represent but a small sampling of relevant titles that at first glance would not be considered healthcare texts per se. On closer inspection, and with the value of critical reading in narrative medicine in mind, however, they make for effective, comparative pieces of literature that can expand practitioners’ understanding of the link between stories and the experiential components of life, death, and all setbacks in between: illness, injury, disease, and disability. To this end, these titles represent narratives that are abstractly and interpretatively medicinal in nature, and where it is up to the reader to uncover what the real-world applicability of the story is to her current experience or professional designation. These types of lesson-driven stories are what are known as didactic narratives, and are essential in terms of how novels, films, and other texts serve the interests of narrative medicine.

A **didactic narrative** is any text, as broadly defined, and of any medium (print, film, television, graphic art, etc.), that serves to instruct or teach some type of moral or logical lesson through the use of story. Frequently serving as a cautionary lesson, a didactic narrative is more than a text that features a moral of the story, but rather, is a narrative that features one or more instructional components embedded directly in the storyline, and ones that are usually fairly specific—though not necessarily obvious. The recognized value of didactic narratives has often depended on the cultural or occupational group it was thought stood to learn the most from them. For instance, the trailblazing half-hour police drama *Dragnet*, which originally aired on NBC from 1951 to 1959, yielded a number of episodes that, despite being produced foremost to entertain civilian audiences, ended up being used as official training films at the Los Angeles Police Academy for many years. In this case, the realism of the series and the narrative’s adherence to proper procedure as portrayed by the actors on screen led to *Dragnet* being considered a superior instructional tool. While not necessarily being referred to as didactic narratives among police recruits, select episodes were nonetheless screened and then discussed by instructors at the academy teaching new officers the basic competencies of front-line policing.

In reality, *Dragnet* is the exception to the rule, as few didactic narratives tend to be this self-evident; yet, as an increasing number of professional, academic, and scientific fields have espoused a multidisciplinary approach to narratives in their curricula, the didactic narrative has emerged as an instructional cornerstone in many academic and now clinical programs. This is in part why many college and university courses, across a wide array of fields of study, now supplement their required textbook readings with filmographies or suggested reading lists that include novels or other works of fiction and creative non-fiction.

A didactic narrative traversing multiple media (stage, print, and television) that has found its way into a number of academic and clinical programs in healthcare is the 1995 one-act play *Wit* (sometimes cited as *W;t*). Originally an off-Broadway production that later moved to Broadway in 2012, it was also produced as a made-for-television film and a book. The stage production, which earned its writer Margaret Edson the 1999 Pulitzer Prize for drama, represents the most effective means of illustrating the role of narrative medicine for the general public, and for explaining the clinical value of storytelling to those outside healthcare. The narrative depicts the final hours of the accomplished life of Dr. Vivian Bearing, a university professor of English literature who is dying from advanced ovarian cancer. The story is told as a series of flashbacks and memories as Vivian recalls her life, doing so through her impassioned command of both prose and poetry. During this same period, Vivian is used as a case study for the hospital's **grand rounds**, where medical residents have her disease and condition explained to them in narrative format, and while visually assessing her symptoms and state of being. The story ends with Vivian dying and the hospital staff, including a young clinical fellow who took one of Vivian's English classes while an undergraduate student before medical school, reluctantly honouring her do not resuscitate (DNR) directive. Beyond being a biography and sad look back at the patient's life, the story connects her memories, passion for literature, her connection with the attending clinicians, and the demonstrative nature of the grand rounds as all being cooperative phenomena. The play is also a wonderful example of how didactic narratives need not be preachy or admonishing in nature, but can sometimes just remind people of what they already know—or think they know.

Didactic narratives, while effective vehicles for learning in not just narrative medicine, but healthcare generally, are also part of the critical reading rather than writing process, where the text being “read” (including being viewed) can expand a practitioner's understanding of how holistic care unfolds through stories. Beyond this understanding, however, narrative medicine necessitates that healthcare providers actively contribute to a body of literature and become critical writers, as well as readers, of these texts. In looking at how the actual writing process in narrative medicine is undertaken, we therefore need to look to the principal mechanism through which healthcare practitioners engage in written composition—what is known as parallel charting.

THE PARALLEL CHART

Parallel charting, as the name implies, describes the process of healthcare professionals maintaining a secondary background chart that complements a primary chart, or patient record. The “parallel” in this type of charting procedure is intended to clearly distinguish it from the institutional chart healthcare professionals will be more accustomed to authoring; however, both charts are concerned primarily with observations of and interactions with patients. Parallel charting therefore implies the existence of two charts—or records—that are written simultaneously or contemporaneously, but that never intersect. While widely recognized as the invention, once again, of Dr. Rita Charon at Columbia University, parallel charting revisits some of the same principles found in a number of types of prose. For instance, parallel charting also contains elements of a separate and pre-existing rhetorical device that is similarly known as parallelism.

As a rhetorical device, or a word arrangement used to serve the interests of rhetoric, parallelism describes the manner in which a sentence is divided into distinct, parallel components that serve as two complementary halves of a larger idea, and that have a common objective. Parallelism is explained in greater detail with examples in [chapter 6](#) of this book, but it is important at this point to note that whether using parallelism in a sentence construction or employing parallel charting as part of a complete suite of healthcare writing competencies, the idea is that “parallel” in both cases means to complement or balance out, rather than directly conjoin. Another key similarity to bear in mind is that parallel charting, like parallelism, ensures a more complete picture of what is being described than any single half on its own; therefore, parallel charting is ultimately concerned with telegraphing, or extending the conventional patient chart housed at a hospital, clinic, or other institution into the personal sphere of the author as part of his own personal records. In doing so, once again the goal is to capture as much insight as possible on patients, their conditions, their wants and needs, as well as their expectations, whether realistic or unrealistic.

Patient Chart _____

Parallel Chart _____

The conventional patient chart authored in the context of a healthcare institution and the parallel chart as a creative undertaking authored by a healthcare practitioner as part of his personal records operate along the same plane, like parallel lines that work towards a common direction but which never cross or converge.

Insightfulness and both personal and professional growth through writing as its main objective is why parallel charting should be distinguished from conventional, institutional charting. For this same reason, the parallel chart need not contain the same level of clinical or technical exactitude as regular records. Instead, parallel charting is supposed to be a comparatively private undertaking, and third parties should seldom read the documents or records authored as part of this process unless the author chooses to share them. Unlike institutional charting, where the documents and records are the property of the institution and subject to disclosure and vetted release, the parallel chart is the original intellectual property of the author and it is not subject to disclosure. This is additionally why it is essential that the institutional chart and parallel chart should never reference each other or otherwise cross-pollinate, in that even indirect mention of the parallel chart as a secondary record in the official chart could disrupt the private dialogue that is at the heart of parallel charting and render it fair game in terms of official disclosure. Maintaining this separation between the two is especially important in circumstances where institutional charts are seized, subpoenaed, or otherwise disclosed as part of ongoing criminal or civil litigation, and where current disclosure standards may negate any privacy interest a healthcare professional—or patient—has in a secondary parallel chart. The purpose of the parallel chart is not to duplicate or replicate the institutional chart, nor to brainstorm clinical ideas that might bear fruit in the care-delivery environment. The purpose of the parallel chart is to use writing as a vehicle for self-assessment and self-reflection—more of a personal diary than any document one might find in the clinical setting.



Now that we have made it clear what parallel charting is not, it is appropriate to begin looking at what types of writing would constitute a parallel chart, as well as how parallel charting and narrative medicine connect. Parallel charting is a type of interactive and narrative-based reflective writing that allows healthcare practitioners—including students, clerks, residents, and preceptees (those training under experienced practitioners with a view to improving their clinical competence)—to write freely about their experiences with patients. In some sense, the parallel chart serves as a release valve for the emotional, psychological, and professional pressures of medicine, and is intended to be part of a practitioner's growth both as a healthcare professional and as a person. Working in healthcare and dealing with a wide array of people and situations is unquestionably a transformative experience, and the parallel chart should be a place where professionals can reflect on this transformation, including both its positive and negative aspects. As practitioners become increasingly experienced and gain new insights, the thought is that they ultimately develop an internal narrative knowledge, or an awareness of how people, places, and events in their career begin to form part of a larger story (Charon, 2008, p. 11). Narrative medicine postulates that this type of narrative knowledge should be nurtured, and that it ultimately serves as a type of reference guide at future points in the clinical careers of healthcare practitioners. In this sense, parallel charts should be of practical use both in the present and later down the road, perhaps when reflecting back on important events or people that helped shape a practitioner's professional style or confidence level. That said, a parallel chart should not necessarily be used as a personal diary per se, but as a piece of writing that is inspired by, and ultimately serves the interests of, patients. While certainly an appropriate place to document and gather one's thoughts as a healthcare provider, it is the necessarily patient-centric nature of the prose that makes it a chart rather than, say, a journal. In other words, while it is a personal text, the parallel chart should yield tangible benefits for practitioners that translate into improved insight, empathy, and performance in the field.

There is no prescribed formula or specific set of circumstances that will lead a healthcare professional to initiate writing a parallel chart, and the decision about when and what to write will ultimately vary by individual. Certain people, depending on factors such as professional experience, training, peers, and personality will respond to patient interactions very differently, and some may find themselves composing parallel charts with regularity while others do so sparingly, perhaps only in the most dramatic or tragic of circumstances. Also, not every patient or clinical encounter will merit a parallel chart, and this is yet another benefit of parallel charting over conventional, institutional record keeping, in that parallel charts and their contents are not mandatory, but discretionary. This means that it is up to each individual to decide when a parallel chart is warranted, and what to do with it.

When considering the innumerable professional and personal benefits of maintaining discretionary parallel charts, one might also question why other professions with comparable demands have not adopted this practice. There are certainly no shortage of other occupations where unpredictable and even transformative situations exist that might affect practitioners on an emotional or intellectual level. They are also the types of occupations where this type of secondary reflective documentation could certainly be of long-term value in terms of both managing stress and enabling professional growth. The difference between healthcare and many other professions, however, aside from the obvious day-to-day requirements, is that nearly every healthcare profession or position that requires patient interaction is more than just an occupation—it is what is known as a vocation. This means that being an earnest healthcare professional, regardless of specialty, is more often than not something that is more than a job, and is something actually inscribed in one's personality; it is more than just an occupation you go to and leave, and it dramatically influences one's values, lifestyle, peer group, and hobbies outside the workplace. People drawn to this line of work seldom do so by default. Most students matriculating in any number of medical, health sciences, nursing, or extended health programs will refer to a career in healthcare as being their calling—something in their blood, suited to their personality, or that they otherwise feel strongly about as a matter of tradition or ideology. The passion shown by those entering or seeking to enter this line of work is also why admittance to undergraduate, graduate, and professional programs at universities and colleges is so intensely competitive. Few other professions are so all-encompassing from the outset, and this in part is why a career in healthcare often means taking one's work home, both literally and figuratively.

It is not uncommon, and in some cases even expected, that a career in healthcare is, second only to family, the cornerstone of one's life. Nurses will frequently attend workshops, conferences, or symposia on their days off, while physicians and specialized clinicians are often found reading and contributing to peer-reviewed scientific journals on their own time. Any number of healthcare practitioners are also actively involved in teaching and research in addition to their day-to-day duties, and a number of them are additionally engaged in publishing, outreach and advocacy initiatives, as well as enterprises ranging from software and e-learning to sitting on public committees. Some of these additional duties and activities are paid, most are not; however, they all ultimately revolve around a healthcare career as being more than daily work routine, and underscore the commitments required beyond the care-delivery environment. Most practitioners would not have it any other way as, in starting a career in healthcare, they have devoted themselves to an ideal as much as a job. There are few careers or lines of work that represent this same degree of 24/7 investment, and even fewer that at the same time require the substantial education, ongoing training, professional oversight, and public trust as healthcare. It is therefore not surprising that the idea of doing additional writing and what most would describe as "work" by definition on one's own time has not caught on elsewhere, and why healthcare professionals have largely been accepting of parallel charting as yet another opportunity to further refine their skills, learn, and ultimately carry on doing what they love beyond the confines of the hospital, clinic, or office.

At the same time, parallel charting does not just appeal to practitioners' sense of professional commitment, but is also intrinsically designed to preserve it, especially in the face of setbacks or burnout. Many healthcare practitioners, especially physicians, are emotionally hardened by the nature of their formal education and clinical training alone (Charon, 2008, p. 8), and the extraordinary pressures placed on specific divisions of healthcare only serves to intensify this process. Additional pressure on specific positions or practitioner specialties also requires a disproportionate number of interactions that are of a tragic or pathological nature. These types of interactions, coupled with long hours, shift work, and being on call, can collectively lead not only to burnout, but also to what is known as detachment.

Professional detachment in healthcare and its consequences is actually a very well-studied phenomenon. It has historically been understood as a necessary coping strategy in care-delivery environments, whereby practitioners emotionally disengage and withdraw from specific situations or people. As a type of strategic distancing, professional detachment might include everything from not sharing personal information with patients or continuously maintaining a "game face" during clinical encounters to, on the more extreme end, forcing oneself to completely disengage and think of patients simply as that—patients, rather than people per se. It is not a matter of insensitivity as much as it is a matter of coping and a mechanism used to mitigate burnout, exhaustion, and becoming emotionally overwhelmed.

As many healthcare professionals insulate themselves from the often terrible circumstances and sights of their work by fashioning a proverbial suit of armour and trying to make themselves impenetrable, there are also, however, some documented perils associated with this type of detachment. For instance, it is now understood that even detachment and withdrawal are not effective methods of preventing what is referred to as vicarious trauma, sometimes called compassion fatigue. Studies (Madrid & Schacher, 2006; Shah, 2010) confirm that healthcare workers are among the most susceptible to vicarious trauma, or the likelihood of suffering secondary psychological trauma as a result of routinely dealing with victims of death, disease, disaster, and tragedy. These same studies and others have confirmed that when left unchecked, coping techniques among practitioners tend to be maladaptive, or self-destructive in nature (alcohol and drugs, social isolation, etc.) and that detachment and withdrawal—in effect denial—can actually aggravate rather than mitigate the effects of vicarious trauma. Thus, parallel charting as a means of re-engaging and confronting these emotions head-on represents a departure from what has unfortunately become a common practice of avoiding one's empathic responses as a healthcare worker. The value of a parallel chart, to both practitioners and patients alike, is therefore one that cannot necessarily be measured, and prevention is typically very difficult to quantify. However, if preventing burnout, detachment, and mitigating vicarious traumatization by using parallel charting as a means of keeping a personal written record of what practitioners are going through and how cases are affecting them is its main function, then the merits of this type of reflective writing are self-explanatory.

WRITING A PARALLEL CHART

Parallel charting, unlike writing an institutional chart, departs from exposition as its main rhetorical mode and draws more heavily on reflective and anecdotal forms of discourse; specifically, it engages methods of prose that reflect description and narration. While exposition is to some extent a form of prose concerned with recounting the basic facts with some additional descriptive elements, parallel charting is not an exercise in writing facts as much as the story behind the facts, and is deliberately, as opposed to incidentally, descriptive. While there is no prescribed approach to writing a parallel chart, these documents should ideally strike a balance between being anecdotal, reflective, biographical, and even autobiographical, and should also preserve the clinical purview of a patient chart or record. In other words, writing a parallel chart

means acknowledging rather than denying the existence of the institutional chart, but without being beholden to it in terms of either content or style.

In terms of style, while the rhetorical triangle is intended to serve as the roadmap for the effective cultivation of ethos, logos, and pathos in crafting pieces of writing that fit within the five rhetorical modes, remember that parallel charts are not necessarily read, reread, or reviewed by anyone but the author herself. That means that there is no real need to persuade or inform in the conventional sense as much as there is a goal to promote growth and cultivate empathy within oneself. This is also why parallel charting is sometimes referred to as **empathic writing**, in that the process is ultimately an exercise in being able to relate to others. The thought is that by writing narratively about what patients are experiencing, combined with what their own observations and intuitions tell them, healthcare professionals can learn to better relate to, and recognize the needs, challenges, and spectrum of emotions experienced by, their patients.

By learning to empathize and relate more directly to patients through parallel charting, practitioners can additionally learn something about themselves and their own ability to communicate. This does not mean that parallel charting somehow leads practitioners to lose their edge, but rather, that writing parallel charts enables them to author their own “postmodern autobiography,” in that many professionals’ life stories begin as biographies of other people (Charon, 2008, p. 75). In other words, the type of empathic, reflective writing inspired through parallel charting allows practitioners to use patient case studies to honestly self-assess. It allows them to self-assess their baseline responses to anger, fear, disgust, despair, and rejection, and also serves as a barometer for what types of cases will trigger emotions in themselves, or that may lead them to consider detaching. Because illness intensifies the way in which people define themselves and the manner in which stories are told and received, the parallel chart allows practitioners to tap deeper into their own instincts than institutional writing does, and enables them to confront what might otherwise be suppressed feelings. Beyond these types of therapeutic benefits, parallel charts also help practitioners assess the true nature of their own writing beyond the comparatively formal and proscriptive writing done in healthcare institutions. The parallel chart therefore represents one of the best opportunities for practitioners to reflect not only on their patient care, but also on the quality and depth of their writing—and without having to worry about external readers or reviewers interjecting.

The following passages represent excerpts of writing retrieved from parallel charts authored by experienced clinicians, nurses, and counsellors, with names changed and details anonymized. These samples have been provided in good faith for publication in this book—to further the understanding of and appreciation for what writing a parallel chart can offer one’s career in healthcare.

This first sample represents a parallel chart narrative detailing the slow onset of dementia, and describes an elderly but otherwise healthy patient whom the author—a general practitioner—has known for many years. Note that the narrative is written in a less formal register, including the use of the patient’s given name rather than surname or noun (e.g., “the patient”), and which immediately distinguishes the parallel chart’s style as one that uses reflective prose and which parallels, but never directly engages, the content of the official patient record.

Charles has been my patient for fourteen years. When he and I first met, he was a machinist for a local grain co-op and had lived a rural, agrarian existence for much of his life. He never wanted for much. His hobbies included playing cards and restoring old cars. I sensed that he had never really been that close with family and he never really felt the social pressure to marry. A couple of years ago, however, he married a secretary at a county charity whose silent auction events he used to supply his old, restored cars to. I question if, now with his Huntington’s having reached its current stage, those few years of marriage seem like a lifetime ago, or perhaps as though they never happened at all. He is lucky to have her, for if it weren’t for that chance encounter, Charles would

be truly isolated and alone in these final years. Charles reminds me that no diagnosis is ever without context, is never ahistorical. No diagnosis is also ever limited to just the patient. I wonder if his wife ever questions her decisions or her resolve, having largely inherited, during what were to be her golden years spent travelling and revelling, a parenting role that she had no doubt assumed had long since passed. Charles, returning to an infantilized state and needing continual attention during this latest phase of rapid progression and degeneration, to some extent reminds me of my own grandfather, in part the reason for my pursuing medicine in the first place. Unlike Charles, ALS—still commonly called Lou Gehrig's Disease at the time—was his final tormentor. I guess in a way I'm glad that Charles is at least unaware of the disease ravaging his body, unlike my grandfather who was lucid and aware of his condition until the final days. Two men, separated by forty years and different diagnoses, but connected in both memory and medical practice through my eyes.

In this excerpt, we see the author, a general family-practice physician, who has taken notice of the rapid decline of a male patient with whom he has developed an affinity over the years. Beyond the official patient chart that documents the male's recent cognitive degeneration as a result of Huntington's disease and its miscellaneous co-morbidities, the parallel chart offers a space for supplementary documentation that is one part clinical, one part philosophical. In this excerpt from what might in many cases go on to become a fairly lengthy treatise and reflective narrative, the author draws parallels between the patient—a patient who is given a name, a personality, and a life history beyond the sum of his official charts and its various bits of nomenclature—and the author's own experiences with a family member prior to entering the practice of medicine.

As a sort of autobiographical retrospective, this particular narrative reminds the author of his inspiration for pursuing a career in medicine in the first place. Beyond serving as a type of memoir writing or imparting the type of cathartic, reflective writing that is at the core of parallel charting, this personal entry may also be of assistance to the author when considering how to broach sensitive topics such as palliative care and estate planning with the patient's spouse, or when discussing specifics with respect to the patient's needs with nursing home staff if he eventually requires twenty-four-hour care.

In this next sample, the author—a psychiatrist—composes a parallel chart entry detailing the complexities of treating a young female patient exhibiting symptoms—both emotional and physical—of a severe eating disorder, but who remains in denial. Moreover, the author is using the parallel chart to document his own questions about how to engage the patient's family as stakeholders in the disease as they collectively move towards intervention and treatment.

When Sara's mother first brought her into my clinic for an initial consult about anxiety, I had no expectations, even for a 21-year-old. Anxiety and depression are, after all, reportedly, and visibly based on my own practice, on the rise among young people in college and university. When she arrived, I could see that in fact the anxiety was something very real and before I began talking with her I could see that her appearance told the story that she would likely never recount. Even though she was predictably circumspect with her words and clearly disdainful of her mother bringing her to me, her skeletal appearance combined with her revealing attire with down developing on some areas, not to mention her ostentatious display of jewellery and what looked to be newly emblazoned tattoos all but confirmed that the anxiety was in relation to struggles over body image and a conflicted sense of sexuality. Excessive exercise, discreet late-night purging episodes, and bingeing behaviour with respect to the accumulation of clothes, acquiring of tattoos, and recycling of friends and boyfriends put Sara into an expanding category of younger girls whose bulimia nervosa goes beyond traditional manifestations. Sara says that she has a "fitness and image-conscious lifestyle," with the word "lifestyle" being routinely stressed. Without admitting it, she seems to be reciting maxims from existing "pro-mia" websites I've already scouted after meeting with other patients, sites that advocate for bulimia as a life choice and a counter-culture with benefits. These purported

benefits are supposed to be social, sexual, and spiritual. Her mother seems to be unfazed by her daughter's boastful references to her friend Mia—a metonym and the metaphorical figurehead of the pro-mia lifestyle. Her mother can't see it and connect all the dots, but knows something is amiss. Sara wants her mother to connect the dots—to deduce that Mia is not a real person but a false idol. Her mother talks about Sara snapping self-portraits in the bathroom mirror with her mobile phone for up to an hour at a time as burnt offering to this perceived deity, and then lying in bed for days if she doesn't get the validation she is seeking after posting them to social media. I wonder how her mother can see so much of what's going on and be so intuitive, but also may be denying at the same level as Sara in terms of the real dangers of what's transpiring behind the scenes.

In this excerpt, drawn from a series of entries documenting the trials of a young female struggling with bulimia nervosa and the toll of her condition and ensuing—and prefiguring—behaviour on her family unit, the author has composed a parallel chart to serve as a stream of consciousness about his frustrations with a number of issues encompassing both the referral and the symptoms. The author uses the parallel chart as a sounding board to flesh out questions, both clinical and cerebral, about how the physical symptoms previously went undocumented or untreated by other practitioners, how the daughter is able to deceive her mother and rationalize or otherwise minimize her disorder, and how the mother, while well-intentioned and concerned, has overlooked aggravating factors that point to the patient's more systemic symptoms. Like the previous example, parallel chart entries of this nature are more than just journal or diary entries. They can ultimately assist in future diagnoses and interventions or in composing journal articles and grand rounds lectures citing anonymized case studies, and where the types of qualitative and reflective insights in the parallel chart can be used as teaching points for other practitioners—as well as renewed learning points for the author.

PORTFOLIO: THE RE-ADAPTATION OF PARALLEL CHARTING

As effective a vehicle for narrative medicine as parallel charting has proven for many practitioners, and while it is still used by some early adopters of narrative medicine, parallel charting has proven to not necessarily be the preferred means for mobilizing narrative medicine today. While narrative medicine has been adopted as one part of practitioners' comprehensive and multidisciplinary skill sets, parallel charting was in many cases phased out as a standard narrative medicine practice in recent years for no specific reason other than it was thought that other more structured forms of writing could be used to assist practitioners in understanding the value of empathic writing. While parallel charting is still used by many healthcare professionals as a mechanism for relating to patients and reflecting on their work, including as a means of mitigating detachment, there is a new trend afoot in both the care-delivery environment and healthcare education alike. As narrative medicine continues to evolve from a conceptual to a practical process, so too has parallel charting evolved from being the equivalent of homework to something that is foundational to the professional development of healthcare practitioners, beginning as early as their time in university or college. It is a process of healthcare communication known as portfolio writing, and often referred to as simply portfolio.

As a single word that has elements of both a noun and a verb, **portfolio** (normally referenced without an accompanying article) is a blanket term that describes a collection of pieces of healthcare prose over the course of one's early career. While portfolio is a practice that can—and in some cases should—become a regular practice in one's career in the way of parallel charting, portfolio is generally used to describe a specific series of written submissions required during clerkship, residency, or apprenticeship in healthcare, and is intended to help early practitioners draw direct correlations between narrative medicine and performance in the field.

As an example of what in English is known as **holophrasis**, or the practice of using a single word to substitute for any number of words or ideas through a single statement, portfolio is simultaneously a tangible collection of writings, an idea, a professional practice, a learning method, and a philosophy. Portfolio is the practice, at varying points in one's healthcare career but intended primarily for use as an evaluation tool in the latter stages of a healthcare education, of completing reflective writing with specific "prompts" and formatting requirements. While this type of regimentation may seem counterintuitive to the idea of narrative medicine as an intrinsic process, the shift from parallel charting to portfolio as the preferred mechanism for the reflective writing process has placed greater value on prompting practitioners to respond to specific stimuli when writing. The idea in doing so is that unless healthcare providers and students know what elements of the chart to parallel in their secondary prose, many may be dissuaded from even trying. Portfolio is therefore designed for use as a basic blueprint that practitioners can follow in introducing themselves to the role of narrative in the care-delivery environment. In healthcare training programs, including medical school clerkships, portfolio is also an essential component of the clinical curriculum.

While the templates used in portfolio writing assignments vary by educational institution or teaching hospital, the rationale for introducing these forms into clinical curricula is to teach new and emerging practitioners to identify appropriate prompts, or incidents that merit reflection and secondary documentation as narratives. These prompts can include the posing of specific questions that require narrative responses. Questions can include having the writers reflect on a time when they sought advice from a mentor, were sought out for advice themselves, dealt with a language barrier, dealt with a personal or professional setback, or spoke to someone close to them who was diagnosed with a serious or life-threatening illness. These questions, which are not unlike the types of questions one might be prompted to answer in a structured job or academic admissions interview, are but a small sampling of the types of prompts that practitioners can use to author response narratives.

In the case of portfolio being used as an evaluation tool in teaching hospitals and other healthcare education settings, the prompts are normally arranged by theme into what are known as iterations, or a series of repeating steps aimed at improving a process incrementally. In some sense, each of these iterations uses narrative medicine to enable progress reports on a student's communication skills and narrative awareness. In many medical school clerkship programs, the completion of these portfolio iterations is deemed a priority and weighted equally to the same degree as clinical exercises. Most of these programs require that the portfolio exercises must be completed to satisfaction in order to progress beyond the clerkship. Whether or not those students, upon satisfactorily completing the portfolio component go on to undertake parallel charting as a common practice during their careers is unclear; however, as other healthcare programs either adopt or consider adopting portfolio as part of an interdisciplinary curriculum, the following sample represents how portfolio writing requirements, delineated by theme, might be integrated into a holistic healthcare education or training program. This includes programs involving professional placements in the field where, like the clinical clerkships that have popularized this model, interactions with patients or the community serve as prompts for reflective narrative prose.

As depicted in this sample outline, and in keeping with narrative medicine's focus on the link between writing and reading as mutually inclusive forms of personal and professional development, healthcare-training curricula that use portfolio will often pair writing exercises with companion texts. These texts may be works of fiction or creative non-fiction, or biographical or historical narratives—or a blend of all of these—and can be either assigned or left to the discretion of students to select. In theory, because portfolio is a progressive process, it may be best to assign texts in the early iterations and allow students to learn how to recognize how comparative literature serves the interests of healthcare for later iterations. As instructors, clinical

mentors, or preceptors assign portfolio readings, special attention should be paid to matching relevant readings to suitable prompts and writing themes. As students reach the end of their portfolio, they should then have the introspection, critical reading and analysis skills, and a general awareness of narrative, to be able to select their own texts and determine how they serve as didactic narratives in healthcare.

Portfolio Iteration 1:

- » Write about a time you felt lost or alone.
- » Reflect on your recollection of the first time you witnessed someone diagnosed with a major illness. Describe the scene.
- » Prompt to be paired with comparative reading: Leo Tolstoy (1886) *The Death of Ivan Ilyich*.
 - i) Describe how the novel depicts terminal illnesses.
 - ii) Describe how the novel might be used as a didactic narrative for practitioners working in palliative care.

Portfolio Iteration 2:

- » Write about a time when you determined the outcome of a clinical or management decision by speaking your mind, even if you weren't asked.
- » Write about a time when you witnessed a patient's gender or cultural, linguistic, socioeconomic, or sexual background have an impact on her medical treatment.
- » Write about a time that you experienced a conflict with a colleague over a patient's treatment.

Portfolio Iteration 3:

- » Recall the chief complaint offered by a patient in a complicated clinical case, and then describe the event as though you are the patient and have no medical knowledge or experience. Record the event as a layperson.
- » Write about a time you witnessed a conflict escalate between a patient and practitioner, describing the event as you think the patient would recount it.
- » Describe the first time during your clerkship a patient placed his absolute trust in you as someone who could make him better.

Portfolio Iteration 4:

- » Describe something that you know now and take for granted that you wish you had known a year ago.
- » Describe something that one of your patients taught you either about yourself or about life.
- » Prompt to be paired with comparative reading of your choice.
 - i) Describe how your chosen text has improved your skills as a medical practitioner.
 - ii) Write a synopsis of how you would describe your chosen text to a colleague and why they should read it.

INTERTEXTUALITY AND THE INTERNATIONAL NETWORK OF NARRATIVE MEDICINE

In recent years, the types of parallel charting and portfolio prompts showcased for demonstrative purposes here, as well as new and emerging applications of narrative medicine, have been recognized as being part of a collective global movement toward what is often described as a

narrative impulse in healthcare. In essence, narrative impulse describes a widespread recognition of there being stories to tell and methods for didactic narratives to be shared among colleagues. In the tradition of comparative literature, this dissemination means going beyond one's own nation, cultural group, and language system, and looking to colleagues in other areas around the world for testimonials about successes in narrative medicine, new and emerging forms of parallel charting, or simply discussing relevant literature and media. Amidst great advances in the scholarship and practice of narrative approaches to healthcare has emerged the International Network of Narrative Medicine (INNM), a global think tank and body of scholars, writers, and clinicians whose aim is to ensure a sustainable future for narrative impulse in healthcare through the organization of conferences, symposia, lecture series, and targeted publications.

The emergence of the INNM allows healthcare practitioners who are able, willing, and comfortable in sharing their experiences and authored work to come together in a common forum and among supportive colleagues representing a wide array of medical and literary traditions alike. The rationale behind the INNM and similar initiative worldwide is twofold. First, it is intended to offer narrative medicine advocates and writers a common place to meet, workshop ideas, and submit written work and stories for review and even publication. Second, the thought is that no matter how personal some stories and experiences seem to practitioners, they are seldom isolated incidents without precedent, and somewhere, someone else has undergone a comparable experience and can benefit from the collaborative environment offered by the INNM. This latter phenomenon, related in part to comparative literature in terms of how multiple texts operate in indirect dialogue with each other, is what is known as intertextuality.

Intertextuality has a very specific meaning in narrative medicine that is not the same as its meaning in the world of literature more generally. It describes how parallel charts and other forms of reflective writing can influence and even alter the meaning of other texts by creating blended stories. Intertextual narratives can either be intentionally crafted by healthcare writers seeking out other practitioners and collaborating or sharing stories, or they can occur entirely by chance, such as reading a narrative in a periodical or journal that seems oddly familiar, or hearing about it through a third party and then realizing that the circumstances are almost identical to something another practitioner has encountered. This is one of the values of an international body like the INNM, in that part of its mission is to bring healthcare writers and scholars of narrative medicine together so that their texts can find a single crucible for the purposes of forging intertextuality. Of course, one potential drawback to seeking out other practitioners' stories, especially those that have themes in common with an existing text, is that those searching might not like what they find. Because intertextuality has the distinct ability to nuance and even recontextualize pre-existing narratives by virtue of their similarities, the differences can be seen by some as tainting or diluting the value of one's own narrative. For example, an engrossing narrative that is a point of particular pride for a healthcare practitioner who closely monitored a patient's progress, including her fluctuations in mood or mental state, and ultimately chronicled her uphill battle to defeat a major disease with the support of the patient's family and healthcare team, may closely align with a remarkably similar set of circumstances elsewhere, but with a much different ending (Sharf, et al., 2011: 41). In the similar but unrelated case, it may be that the patient ultimately succumbed to her illness, or was abandoned by loved ones in her darkest hour. In the ensuing intertext, one finds that there are no predictable or formulaic outcomes in healthcare narratives, and that blending anecdotes in this fashion often leads to more questions than answers—questions of fact, questions of procedure, and questions of hope.

While this is sometimes cited as a drawback to intertextuality and expanding the scope of healthcare narrative practices beyond one's immediate professional circle or the system of care one is accustomed to, the work done by groups like INNM—which launched only in 2012—reminds healthcare professionals who are either newcomers to parallel charting, or who have

been its early adopters and innovators, that endings to narratives cannot be contrived, expected, or predicted, and that the ending is only one part of the story. An unfortunately or declaratively “bad” ending in one circumstance does not therefore negate the good work done—nor does it invalidate “good” endings experienced by practitioners under similar circumstances elsewhere. This is a reality of narrative medicine that, during its ongoing sophistication, will ultimately remind practitioners of its roots in comparative literature and critical reading, including a reminder that even if two similar cases present with the same clinical ending, no two stories will ever be told the same way.

NARRATIVE MEDICINE AND HEALTHCARE REFORM

As narrative medicine continues to evolve and find expanded applications, some of its more immediate benefits are already being reaped in terms of how structural changes to healthcare are enabling new forms of communication between practitioners and patients. While advocates of narrative medicine see it as being able to (re)humanize medicine in an age of corporate hospitals, there are in fact everyday operational consequences—of a positive nature—that stem from narrative medicine’s philosophies. In [chapter 1](#) of this book, for instance, the role of linguistic registers in healthcare was discussed in the context of shorthand and patient charting. Beyond conventional charting and how accepted registers enable the use of accepted abbreviations that might not be understood by those outside of a healthcare communication system, parallel charting has in a roundabout way engendered the emergence of new registers altogether, including the creation of new hybrid categories of healthcare practice—specifically with respect to physicians—that are rooted in fundamentals of narrative medicine.

A recent trend in Canada and the United States, coming on the heels of an expanded awareness of how narrative medicine and parallel charting mitigate what are sometimes seen as transactional and impersonal models of patient care, is the emergence of what’s known as the MD-therapist. Traditionally speaking, family physicians with their own general practice or practising as part of a healthcare team have prided themselves on being able to cultivate and maintain long-term relationships with their patients and their families. But the ending of house calls and the emergence of alternate and competing forms of generalized healthcare delivery, including walk-in clinics, urgent care centres, telehealth initiatives, and integrated medical-mart style facilities have changed the nature—and expectations—of what family physicians are able to deliver. What some critics suggest has ensued in recent years is an assembly-line system of processing patients that reflects commodified hospital systems, reflects a larger medico-industrial system that impacts everything from medical school admissions to pharmacological research. With an aging population and fewer medical students opting to pursue careers in general practice, the burdens on family medicine have reached something of a critical mass. In many regions, patients are unable find a stable general practitioner, with many family physicians being unable to devote the time and attention they would like to their existing patients, let alone take on new patients. The result of this overloading of primary care delivery systems has been a trickle-down effect to all levels of care and specialties of medicine, with patients who might have historically gone to their general practitioner about a non-emergency medical concern now having to attend the emergency room, and with wait times to see specialists increasing exponentially from there. In this ensuing confusion, one of the last vestiges of the patient-physician relationships in the context of family medicine has been left hanging by a thread: the general practitioner as not only a healer, but as a listener, counsellor, and advisor. Narrative medicine, now recognized as an integral part of holistic healthcare, has been a major influence in helping general practitioners recover this element of their practice.

With the pressures faced by general practitioners in terms of time management and patient overload, it has become increasingly difficult for physicians with general family practices to

preserve their ability to attentively listen and to maintain roles that have now been downloaded on to the other public sectors, specifically with respect to counselling services. What has ensued in recent years is a missing link between family medicine and psychiatry, with general practitioners often not having the time or resources to counsel patients who are in mental or emotional distress, but who are not necessarily in need of pharmacological intervention or the services of a clinical psychiatrist. The consequence is that many patients who, unable to be treated by their family physician and not qualifying for the medical insurance required to see a psychologist, would unnecessarily seek referrals to psychiatrists more accustomed to dealing with advanced cases of mental illness and treating identified mental disorders rather than offering general counselling and therapeutic discussion. Narrative medicine and its advocacy of the way in which treatment can be improved through expanded discourse and attentive listening and discussion ultimately shored up this deficiency and helped advance practical healthcare reforms.

General practitioner-counsellors, or MD-counsellors, as they are often referred to, represent a new area of subspecialization in medicine that places increased emphasis on physician–patient interaction and discourse, rather than on a system of expedited assessment, treatment, and pharmacological intervention. The shift towards the MD-counsellor model in many cases represents existing and experienced physicians who have vacated their existing general practices to focus specifically on counselling and psychotherapy, while at the same time maintaining their ability to prescribe medications if required. What interviews with a number of these hybrid practitioners have revealed is that patient interaction and listening and responding to patient concerns has always been one of the tasks they felt was most important to holistic care, yet was also the one task that they historically had the least control over. In many cases, these were patients who did not warrant escalation or referral to a psychiatrist, yet who also required more one-on-one time than a standard visit to a general family practice would allow. The fact of physicians shifting their practice to focus specifically on these types of counselling services has subsequently alleviated constraints on both family practices and psychiatric services, at least based on early anecdotal evidence. The emergence of the MD-counsellor has been found to be a much-needed bridge between the essential delivery of medicine and physicians being able to provide holistic care in the truest sense.

What these types of reforms inspired by narrative medicine may ultimately mean for healthcare writing and communication in a broader sense could prove to be significant. For one, the MD-counsellor as an increasingly accessible and diverse medical practitioner has the ability to change expectations with respect to physician–patient registers. While registers (see [chapter 1](#)) tend to vary by institution, physician–patient encounters are usually both formal and consultative in nature. The MD-counsellor hybrid model represents a change in this practice, with the emergence of similarly hybrid registers that—given the liberty of time and necessarily interactive nature of the discourse—brings physician–patient exchanges towards a consultative-casual level of formality. As the physician and patient develop an increasingly familiar relationship defined by openness and not constrained by story editing, this change in register will in turn have a corresponding impact on the practitioner’s writing, from official note taking to parallel charting. As scholarship on narrative medicine and practical changes to healthcare-delivery models continue to align, the importance of practitioners being adaptable in their healthcare writing will become increasingly evident. This adaptability includes not only the willingness to adopt narrative-based approaches such as parallel charting, but also adaptability in terms of the writing medium, which is the focus of the [next chapter](#).

CHAPTER SUMMARY

By this point, you should be able to:

- Differentiate between everyday reading and critical reading, as well as between parallel charting and portfolio writing as two forms of critical writing rooted in narrative.
- Understand how narrative medicine and bodies like the International Network of Narrative Medicine are creating a certain storytelling impulse throughout all levels of healthcare, and how this impulse is leading to clinical reforms like the emergence of the MD-counsellor.
- Discuss how books and other texts created for various media can impart new insights into common healthcare and human problems, and offer new ways of understanding the patient experience.
- Define didactic narrative, multidisciplinary, and empathic writing, and be able to explain how all three converge under the umbrella of narrative medicine.

Some self-check or class discussion exercises you might want to try include the following:

- Select a book or film that has been deemed historically or culturally significant—or that you simply like—and ask yourself if it might have some applicability to healthcare as a didactic narrative.
- Have a look at the sample portfolio iterations and try responding to them by writing out a personal essay that relies on the narrative prompts provided.
- Critically examine the sample parallel chart excerpts and try to get a sense of how the authors are using the medical problem presented as a roadmap to the larger personal back story of their patients and the social determinants of their healthcare issues. Try to get a sense of how the authors are using the parallel chart to help themselves work through the best ways of treating the patients and offering the best care.
- Conduct some online research of your own into graduate courses of study on narrative medicine throughout Canada and the United States, including the foundational Master of Science program at Columbia University and its associated workshops and sponsored projects.

As an aptitude for healthcare writing and a command of rhetoric is increasingly expected to mirror one's clinical skills in care settings, healthcare writing is also becoming increasingly diverse in its scope, evidenced in part by the adoption of narrative models discussed in the [previous chapter](#). At the same time, practitioners are being expected to expand not only their writing repertoire to include a blend of institutional and narrative documents, but also adopt new writing platforms and interfaces altogether. These changes in format are intensified by rapidly changing applications of technology, through what is known as “technological determinism” (Ellul, 1964). This means that the rigours of healthcare writing today and its ever-evolving facets are the direct consequence of technology, rather than technology being designed to suit the demands of institutions. In others words, it is technology that shapes the content and style of writing, not vice versa.

The healthcare profession is additionally unique with respect to how technological determinism extends the institutional writing model beyond the hospital, clinic, or other care-delivery environment into various media where it can take on a life of its own. Unlike narrative medicine that was originally designed to be personal and reflective in its form, technology to some extent merges narrative medicine and the parallel chart with the institutional chart to create what we call [hybrid documents](#). These documents are written records or forms of prose that really have no precedent prior to the internet, and that blend elements of both the expository charting and descriptive parallel charting in one text.

Hybrid documents as the offspring of the internet and innovations in multimedia include the various types of writing discussed and presented in this chapter, and they are writings that are almost inevitably electronic in format. They are documents that are composed electronically and that blend elements of both expository institutional writing as found in conventional care-delivery environments, and the descriptive writing more commonly associated with narrative medicine. Another factor, perhaps the key factor in classifying these forms of writing as hybrid in nature, is the intended readership. Just as the documents themselves draw from two distinct writing customs and registers, so too are they intended for both professional and general audiences.

Healthcare practitioners as the authors—and readers—of these documents are in the interesting yet challenging position of straddling two spheres; they are simultaneously exposed to and acted upon by two mutually occurring and continuously changing technological worlds. Hybrid documents designed for primary dissemination via electronic media, specifically the internet—online pathographies, medical blogs, and healthcare wikis—all represent forms of narrative that make use of public technologies and to some extent, through their open access and interactive nature, epitomize what public medicine is all about.

Because of the expressly public nature of these writings, content also tends to vary greatly. In the tradition of the anthological writing model used in patient charting, where a patient record can have many contributing authors, hybrid documents written for the internet also frequently involve numerous writers. These authors can include, at times, both healthcare professionals and patients, as well as scholars or pundits not necessarily practising medicine or serving as

healthcare practitioners, but who are still actively contributing to the ongoing discourse on healthcare or a particular healthcare-related topic. This chapter explores the relatively brief history of online writing as it relates to healthcare, including an overview of the theory and practice behind the creation of some of the more commonly found hybrid documents currently populating the internet.

TELEMEDICINE TO CYBERMEDICINE

One of the more rapidly changing—and technologically determined—models of healthcare communication is found in what's known as telehealth, or telemedicine. As this model has adopted an increasingly diverse array of technologies and patients alike, the term has evolved to include ehealth (sometimes written as e-health or Ehealth) and more recently cyberhealth, or cybermedicine. While some of these name changes simply reflect examples of what are known as **phonoaesthetics**, the rapidly evolving nature of telecommunication, including the asynchronous nature of internet-based writing and reading, has necessitated ongoing revisions to wordings so that they accurately reflect the dominant technologies. As the wordings get further streamlined, ehealth and cybermedicine tend to be used interchangeably, and are considered by many practitioners to be synonyms describing the same thing—which is also telemedicine. If this sounds confusing it's because technologies have been evolving at a pace that requires ongoing revisions to terminologies and also the creation of new terms altogether—terms that then quickly become outmoded. For instance, while “tele” translated from the Ancient Greek meaning “from or at a distance” originally denoted the use of a telephone or facsimile (fax) machine in early versions of telemedicine, it now describes a broad spectrum of distance-based medicine and the increasingly diversified forms of writing associated with it.

There was and remains much debate among both healthcare practitioners and scholars of writing about what types of documents fit within the matrices of telemedicine, ehealth, and cybermedicine. While some suggest that all electronically supported or computer-mediated texts—from patient records to consultants' reports to prescriptions—represent examples of telemedical communications, others, including the American Telemedicine Association (2014) have advocated a more singular and focused definition. While not a distinct medical specialty by definition, telemedicine does include very specific applications or extensions of existing procedures customized for remote locations; this includes using technology to actually conduct medical procedures, such as conducting remote surgeries using robotic devices. One thing that most professionals seem to agree on is that while telemedicine can include any type of distance-based delivery and often relies on asynchronous communication (sending and receiving not necessarily occurring at the same time), and while ehealth describes any computer-supported iteration of healthcare, it is cybermedicine that specifically describes healthcare delivery, education, communication, and writing exclusively in the context of the internet. As this chapter examines medical narratives in the context of the internet, it is therefore cybermedicine that is of greatest relevance to healthcare writers, and the one that we will be discussing from this point forward. It might therefore be useful at this point to explicate each of these terms as follows:

- **Telemedicine:** The practice of medicine—including procedures, diagnoses, advice, assessments, prescriptions, and consults—conducted remotely using any number of technologies, such as telephone, facsimile, or internet connection.
- **Ehealth:** The practice, administration, informatic regulation, and business applications of medicine—also known as Health Information Exchanges (HIEs)—through the use of information technologies. These technologies include not only the internet, but also

intranets and extranets (restricted access networks), internal databases, and any type of computer-supported infrastructure.

- **Cybermedicine:** The practice, theory, and collective narrative of medicine as broadly defined and as carried out in the context of the internet. Cybermedical writings and communications, as well as patient care-delivery models, can be carried out using listservs, educational portals, public health websites, news sites, podcasts and vidcasts, open access or open source discussion forums featuring pathographies written by both practitioners and patients, and healthcare blogs and wikis.

The fact that cybermedicine is indigenous to online environments allows all affiliated types of electronic writing to exploit the full interactive potential of the internet, including texts that encompass numerous rhetorical modes and which draw on multiple linguistic registers. While telemedicine as the progenitor of cybermedicine has historically made use of various distance-enabling technologies, it also customarily deferred to a consultative register and was originally conceived to offer alternatives to in-person point-of-care interactions. Cybermedicine as a blend of both telemedicine and ehealth has come to include a much broader variety of interactions and communications, enabling the creation of new and innovative texts that go beyond these types of traditional practitioner–patient interactions and the dissemination of only clinical data. In enabling the authorship of hybrid documents that bridge the distance between exposition and description, as well as institutional charting and parallel charting, cybermedicine is a comparatively holistic and inclusive forum defined by both narrative and care delivery. It is also a conceptual practice that makes healthcare more accessible through a wide variety of writings for various audiences and reading levels. Beyond just practitioner–patient communication, cybermedicine enables communication between patients and other patients, practitioners and other practitioners, and even patients, practitioners, and researchers at once. Like narrative medicine, cybermedicine is defined by multidisciplinary and inclusivity, and is ripe with writings that prioritize narrative and description not necessarily to the exclusion of exposition, but as a complement to it.

Cybermedicine as a multidisciplinary phenomenon has also quickly established itself as an important research tool. Research in this context includes not just clinical and scholarly study as might be expected, but also regular everyday people educating themselves on any number of healthcare-related topics. As the internet emerges as the dominant means by which patients self-assess or pre-screen their symptoms prior to attending hospital or other primary care facilities, the written content on health-related websites draws a direct link between narrative, diagnosis, and timely patient care. In some sense, cybermedicine and the electronic testimonies found online represent the most immediate publishing outlet for narrative medicine advocates and authors alike. With recent studies (Fox and Jones, 2009) indicating that up to 61 per cent of North American adults rely on the internet and cybermedical sites as their primary source for learning about illness and disease—as well as to self-diagnose—cybermedicine is fast becoming the most public and widely penetrative form of healthcare writing.

PATHOGRAPHY NARRATIVES

One of the most prevalent narratives in the world of cybermedicine, yet one that also predates the internet and has existed in various media and literary forms over the generations, is what is known as a **pathography**. As the word construction suggests, a pathography combines elements of pathology and biography, a literary device known as a **portmanteau** where two or more words—along with their original meanings—are combined into a single word. Pathographies represent some of the more prevalent forms of narrative writing on the internet and are an effective

example of how new media technologies and the access to information afforded by the internet enable what are known as health information-seeking behaviours (HISBs) among the general population. Accessing timely information on healthcare options, as well as narratives about experiences with illness, disease, and disability, have been demonstrated to have a significant impact on how and when patients seek medical attention, as well as how they cope with diagnosis, including pre-screening and self-diagnosis practices. HISBs are therefore linked to effectiveness of care, compliance with specific care regimens, and ultimately long-term prognoses (Galarace, Ramanadhan & Viswanath, 2011). In other words, online medical narratives such as pathographies are more than just examples of reflective writing in the vein of the parallel chart—they have a direct impact on the practice of medicine and on both wellness and longevity.

Pathographies are narratives that include a broad spectrum of text and media types, and that have been used by healthcare professionals—typically physicians—for many years as educational and awareness tools. Pathographies are not, however, strictly a product of the digital age. While the internet has enabled faster and more widespread access to narratives discussing the causes and effects of disease, the reality is that pathographies represent a form of healthcare writing that began as a narrative internal to specific healthcare institutions and their communities of practitioners, and which has in recent years expanded to include external contributors. Pathographies were initially written as texts that combined elements of both exposition and narration by medical experts, typically during the course of clinical research, epidemiological investigations, or when contributing to a particular scientific study.

Dating back over a century, British physician and epidemiologist Dr. John Snow's study of the 1854 London cholera outbreak is perhaps one of the better-known examples of pathography writing in the context of a medical investigation. In examining and documenting an outbreak that killed 127 residents of a single neighbourhood in the first 72 hours before spreading across the city of what was then a population of just two million, killing over 600 people and having a mortality rate that in some neighbourhoods approached 15 per cent, the prevailing opinion at the time was that airborne germs as a result of pollution and "bad air"—a consensus at the time known as Miasma theory—was to blame (Johnson, 2006).

Enduring as one of the key medical investigations in history, and one that is inscribed in the epidemiological research methods used by agencies such as the World Health Organization (WHO) and United States Centres for Disease Control (CDC) today, Snow was, using detective-like deduction and geographic profiling, able to trace all of the early infections to a contaminated water pump located on Broad Street (now Broadwick Street) in London's Soho neighbourhood. The idea that contaminated water was one of the most virulent and lethal means of transferring disease, in this case as a result of underground cesspools of human waste seeping into the water table, was radical at the time. By simultaneously disproving Miasma theory and locating the origin of the cholera infections, Snow's investigation put an end to the outbreak, and his ensuing pathographies written about the nature of cholera and infected water had a profound impact on the design of city sewers, water treatment facilities, and municipal sanitation practices. His writings also had a significant impact on epidemiology as a medical specialty and how the origins of outbreaks are tracked and contained. What is additionally interesting to note is that Snow's methodology in identifying the origins and movement of the disease was rooted in his 1849 pathographic essay *In the Mode of Communication of Cholera*, a pathography that was re-published as a second, revised edition in 1855. Dr. Snow's work in saving lives and improving the understanding of not just cholera, but disease generally, was based on evidence gleaned from an earlier pathography—albeit one written by him—and then formed the basis for a second pathography that found an international audience and inspired great reform.



John Snow memorial and pub, Broadwick Street, London, 2005. Photograph by Justin Chadwick. This image is licensed under the Creative Commons Attribution-Share Alike 2.0 Generic license.

For the next 150 years or so, pathographies as narratives about the life course and origins of disease following either a specific case study, like the Broad Street pump, or written as a result of a review of the related literature, have resulted in the authorship of countless papers written almost exclusively by and for medical professionals. The exception to this trend for much of the nineteenth and twentieth centuries was the use of the term pathography to describe biographical writing carried out by authors outside healthcare. In these cases, borrowing heavily on the work done by medical investigators, authors examined the life of a specific person, rather than a specific disease, doing so in the context of how illness, morbidity, and mortality influenced that person's life. In other words, outside healthcare, pathographies have traditionally been used as narratives that amount to medical biographies of historically well-known people, and were often published as books for general interest readers. The rise of the internet and the increasing relevance and accessibility of cybermedicine changed that, and has reconciled both genres of pathography writing, thereby enabling the creation of narratives that can be written either by healthcare practitioners or their patients, and that find readers among both.

Online narratives that fit the definition of pathography writing can take many forms and employ any number of delivery platforms. Pathographies written by healthcare professionals, for instance, will often be published to the internet as weblogs, or blogs as they're now universally known, over which the author retains complete editorial control. Medical blogging is covered in detail in the next section; however, there are also other mechanisms for publishing that can be used by healthcare writers to globally disseminate their observations on a specific illness, or with respect to healthcare-relevant issues generally. Options include writing opinion-editorials (known

as op-ed pieces) for online periodicals or newspapers that have a general audience, or publishing in electronic journals and other downloadable texts that are intended for a professional audience. In these circumstances, however, the pathography is subject to the editorial and creative control—and is ultimately owned—by third parties. While medical professionals and healthcare practitioners are often accustomed to writing for publication and sharing the results of their research in various forums, both online and offline, the way in which the internet has democratized access to information and HISBs among the general population has led to large sections of patients authoring their own pathographies.

As patients and non-medical professionals situate themselves within the narrative medicine model and come to learn the importance of reflective writing in service to holistic care, there are a number of virtual communities designed to be used as both message boards and sounding boards for patients who are either self-assessing, creating awareness, or looking to connect with others undergoing the same treatment or experiencing the same symptoms. Sometimes these contributors are people who simply, as portfolio is designed to do with new and emerging practitioners, have a narrative impulse that compels them to write empathically and in cathartic fashion online. A number of these pathography narratives contain autobiographical elements in the context of disease, with authors attempting to medically investigate the early causes and origins of what has happened. Some of these pathographies, like parallel charts, are written for private use and reflection but a great many are published electronically, most often in online community forums designed expressly for this purpose.

Open access virtual communities and message boards that tend to be organized thematically according to illness or disease represent the readily accessible and searchable sites where these types of autopathographies can be found. These same online forums also reflect some of the principal objectives of pathography writing, in that it is intended to create awareness and foster group dialogue.

Anxiety looms when discussing my diabetes

Well, it's a year later and it's no easier broaching the topic of my diabetes with anyone outside my immediate family and some old friends. Co-workers are probably the worst, especially when I'm only there on contract for now. I hate not knowing how people will react or what their stereotypes are. I guess I hate the unknown and not really feeling like I'm in control of my body, especially when discussing a disease I still don't fully understand.

Speaking of being at work, my employer is notorious for employing hire-to-be-fired contractors, so there is a continuous shuffling of desks and movement around office with respect to who sits where. Last week, I was moved close to two attractive co-workers and I feel like when I have a severe low, they won't necessarily know what I mean if I broach it. I also fear an embarrassing episode if I don't first bring it up. Finally, I asked my boss to be moved back to my last spot in the office where I had gotten to know my co-workers. He agreed and moved me back but now one of them has left the company and there is yet another new employee RIGHT beside me. I can't ask to be moved again and already feel like a burden—not to mention embarrassed b/c I know the women beside where I was moved are aware I asked but don't know why. They are likely speculating as to why and their guesswork is probably even worse than the real reason.

Call me crazy, but I don't feel like my disease should be so central to my workspace and so continuously on my mind. I also don't feel like I should have to explain the ins and outs of my diabetes to other professionals, peers and colleagues ... then again, if something goes wrong, I may end up having to trust that they know what to do. My life may depend on them. Then again, it may not and I may be accused of being a TMI person.

Has anyone else dealt with this in terms of diabetes? Is there a professional and discrete way of making my diabetes known to the people in the office without making it look like I expect preferred treatment or to be treated differently? Sure someone else has dealt with this....

In this excerpt from an online diabetes discussion forum, a patient currently adjusting to life with type-2 diabetes discusses the impact that the diagnosis has had on his daily routine, specifically with respect to any modifications that need to be made in the workplace to accommodate the illness and the author's reluctance to discuss it with those outside his intimate register. While not detailing the disease in specific, including the nature of the diagnosis, risk factors, and any special circumstances that might merit discussion in the same fashion as a pathography written by a clinician, the content of this pathography is specific to the readership for this particular forum; namely, it is intended to offer support and use narrative of experience as a means of educating others about the effects of disease not necessarily reflected in medical literature.

Some pathography sites diversify content by having separate sections, sometimes called "lounges," "social circles," or "support networks," populated with content authored by patients and laypersons, and additional sections that use titles like "news" or "announcements" that contain either original content authored by healthcare providers, or provide links to news stories and published scientific research external to the site.

Pathography sites are also valuable resources in the context of HISBs for those seeking to self-diagnose or otherwise seeking validation for their suspicions that they may be experiencing or exhibiting symptoms consistent with a particular illness. The following excerpt, submitted to a Canadian forum for patients suffering from multiple sclerosis (MS) is authored by an as yet undiagnosed female who fears she may be experiencing early onset symptoms and is seeking guidance from those already using the site for education and support. In this sense, the author is opting in to a very specific community with its own culture and writing register, and is relying on the experiences of other users to obtain a second opinion, or at least supplement the information provided by medical professionals, including her own general practitioner and a specialist.

Hi all: I am a 37 year old woman who is looking for some advice. A week ago, my left foot developed Foot Drop, and now it seems I can't walk properly. As well, my left arm has become noticeably weak. My family doctor is referring me to a neurologist for an EMG test. Obviously, I am confused and worried about just what is going on with me, and I'm hoping someone here can help me out. Let me tell you about some of my past medical experiences that I think could relate to the problems I'm having now.

When I was a kid, I would occasionally experience often quite severe pain and weakness in my legs. My pediatrician prescribed muscle relaxers, which didn't really seem to do much. I have been pretty clumsy all my life, but only off and on (LOL!!!). But in all seriousness, I would go through periods when I would walk into walls and doors and stumble all of the time. There would also be periods when everything was fine. As long as I can remember, I have also had periodic numbness or pins-and-needles sensations in my hands and feet. Also, I tended to drop lots of things, even if they weren't especially heavy. I still do.

Bowel issues have been a long-time problem for me too. About two years ago, I had a colonoscopy done at one of the hospitals here in London, and everything checked out fine apparently.

Here's something kind of weird: I am tender to the touch all over my body. Sometimes, even the smallest push on my arm or leg causes me severe pain. I have in the past been on anti-inflammatory medication; I have also tried acupuncture and herbal remedies. I always assumed

I had Fibromyalgia, but I have never actually been diagnosed with it, and my current family doctor doesn't think that's it.

This past summer, my left leg became severely, severely painful and numb for over a week. I couldn't even walk! My doctor sent me for ultrasounds more than once but couldn't figure out what was causing my pain. The sensation I currently have in that leg is more like a tingling, combined with some feeling of cramping in my calf and Achilles tendon. I also have a similar tingling sensation in my face and arms.

So this is my question: does anybody here think I might have MS??

This submission to ThisIsMS.com, using a casual register and authored by a patient frustrated with an unclear diagnosis and in turn seeking out others suffering with MS as experts in their own right, is emblematic of the way that pathographies are used to self-diagnose or at least pre-screen oneself prior to meeting with a medical professional. This same access to information and the manner in which online pathography forums allow patients to circumvent traditional routes to assessment and diagnosis would seem on one hand to be lessening the burden on the healthcare system by creating better-informed patients. As patients can now more appropriately triage their symptoms and access timely information that can lead them to make more informed decisions about when to attend hospital or make an appointment with their physician, pathography sites and discussion boards have done a great service to many. That said, the fact that much of the information contained in these sites cannot be sourced and is written—and read—subjectively and often without context, has led to a new problem: cyberchondria.

Like pathography, [cyberchondria](#) is itself a portmanteau, and one created specifically in response to the convergence between healthcare and the internet through the online pathography. Cyberchondria is also an example of a [neologism](#), or a newly invented term that is still in the process of being adopted and coming into regular use, and which may not yet be reflected in current dictionaries or encyclopedias. As an alloy of “cyber” that describes any internet-based phenomenon like cybermedicine, and “chondria” from the second part of hypochondria, a well-known anxiety disorder relating to an unfounded preoccupation of having one or more severe illnesses, cyberchondria describes how pathographies can induce an unfounded or unreasonable belief among internet users that they have a particular disease or disorder. Dating back to a 2008 study published in the *New York Times*, cyberchondria is indicative of the double-edged sword of HISBs in the context of online pathographies. While the internet certainly amounts to an effective source of information and contains some sites that can enable for proper pre-screening among some users, some online resources—even effective and credible sites—can also lead to misinterpretation, anxiety, overanalysis, and ultimately irrational paranoia. Many internet users accessing pathographies and reviewing the associated narratives and list of symptoms seem to inevitably draw imagined or inflated connections between their own symptoms and the worst-case scenarios presented online. While recent research (White & Horvitz, 2009) indicates that cyberchondria is still statistically rare among HISB-oriented internet users, it is another example of the link between healthcare communication and technological determinism, with cyberchondria being not so much a medical issue as much as it is a writing issue.

Cyberchondria involves HISBs that grow to take the form of excessive online research, and which frequently lead readers to misinterpret what might otherwise be innocuous or routine symptoms as being more severe than they actually are. As cyberchondria prompts subjective, or self-assessed, symptoms to become unnecessarily escalated by readers of pathographies, the online narratives submitted by both practitioners and patients become misused as strict diagnostic tools, rather than forms of narrative medicine and outreach. While some forms of cybermedicine and online healthcare writing certainly can have direct clinical applications,

pathographies are not necessarily intended for this purpose. Used appropriately by both authors and readers, pathographies represent a remarkable opportunity to use healthcare narratives to assign social histories to illnesses, to establish patterns in patient experiences that can assist in everything from quality of care to tracking illnesses as part of an epidemiological research model, and simply to create a sense of community.

It is interesting, once again drawing on the model of technological determinism, to observe how, why, and when changes in media and specific delivery platforms can so drastically effect changes in healthcare writing and culture. More specifically, one can see how electronic modes of documentation and the rise of networked technologies have not only enabled the creation of cybermedicine as its own form of healthcare communication—in essence its own writing genre—but also how the pathography as subgenre of cybermedicine has evolved in terms of the rhetorical modes used as compared to earlier, pre-internet versions. Initially, when authored in analogue format and when there were only a handful of potential publishing platforms for pathographies, such as traditional scientific or medical journals, this type of healthcare writing was the bailiwick of research clinicians and other practitioners, like Dr. John Snow and others, actively engaged in professional writing and conventional publishing. Over the course of history, some of these pathographies have included book-length narratives, which, when not written by healthcare professionals for other clinicians and practitioners, have tended to be written by accredited authors or journalists and focus on well-known historical figures or celebrities and their struggles with disease. Some full-length books to use this formula have included experts across various disciplines writing pathographies detailing the lives of historical figures that have included Tutankhamun, King George III, Lord Byron, Friedrich Nietzsche, Franklin Roosevelt, and Freddie Mercury. While both of these early versions of pathographies—before the term became widely known among the general public—employed some elements of narration, they were less descriptive in the rhetorical sense than one commonly now finds in online versions. This is because, traditionally speaking, pathographies were intended for professional, clinical, academic, and generally more discriminating readers, employing more in the way of chronological exposition and terminology and focusing less on a detailed description of a given illness and the patient's personal perspectives. The democratization of the pathography through new media technologies, and the increased access to information and publishing enabled by the internet have changed both the author pool and intended audience for pathographies. In the context of cybermedicine, the pathography now exists as a description- and narration-based style of prose that provides a purely anecdotal approach to the patient experience—as experienced by the patient.

With the shift from the early internet, sometimes retroactively referred to as Web 1.0, to Web 2.0, or the next iteration of the internet and the version commonly associated with social networking and blogging in the late 1990s, academics and technology providers alike began to take note of a trend in computer-mediated narration that espoused anecdotal approaches to illness and disease. One of the early medical journal articles (Hawkins, 1999) highlighting this trend among healthcare practitioners described pathographies for this new age of electronic storytelling as being divisible into four categories: the didactic pathography, the angry pathography, the alternative pathography, and the ecopathography.

The way in which various online platforms accommodate one or all of these categories of pathography, and the manner in which pathographies as a response to HISBs have come to dominate some regions of the internet, have merged two key developments in the evolution of writing studies: the digital humanities and the medical humanities. The term **digital humanities** describes the way that computing, specifically the multimedia treatments of text, as well as electronic forms of information storage, retrieval, and exchange have impacted humanities disciplines such as English, writing, and literary studies. At the same time, the term **medical humanities** describes the way in which those same humanities disciplines have intersected with

medicine and healthcare either as a direct result of specific technological changes, or in more indirect fashion, for instance as a result of a larger shift in culture and thinking inspired by such changes.

- **Didactic pathographies:** Like the use of didactic narratives in healthcare, this category of pathography can be described as being an autobiographical account of illness, disease, or disability intended to impart some lesson. Moreover, the didactic pathography both educates and informs the reader (exposition) while also serving as a personal journal or set of memoirs for the author, and whose prose will often reflect the state of the illness and the prognosis through the use of either metaphorical or reflective details (description and narration). This is arguably the most common type of patient-authored pathography found online, and the type most commonly associated with cyberchondria given that it focuses heavily on how the malady first presented itself in terms of symptoms, or how it was identified and diagnosed.
- **Angry pathographies:** This category of pathography is unique to more recently emerging online versions of autobiographical healthcare narratives and, as the name suggests, reflects anger, despair, and outrage. However, this anger is frequently not a matter of patients being angry about their medical circumstances or the state of their illness, but more so their being angry about what they see as their victimization by the healthcare system. These pathographies typically dwell on perceived inadequacies of care, impersonal treatment by clinicians and health insurance providers, alienation and a lack of dignity during hospital stays, and can also function as critiques of the effectiveness or unwanted side-effects of specific medications or courses of treatment.
- **Alternative pathographies:** As an adjunct of the angry pathography, the alternative pathography takes exception to traditional medical practices and the impersonal nature of what is sometimes touted in this category as money-motivated collusion to maintain the status quo between corporate hospitals, private industry, and pharmaceutical manufacturers and distributors. Unlike the angry pathography, this category is less about critiquing what is done poorly and more about what preferable but usually unadvertised alternatives can offer. Sample texts in this category would include narratives discussing the successes and failures of experimenting with naturopathic or other alternative treatment models. These alternatives can often include potentially dangerous or maladaptive combinations of prescribed and non-prescribed medical cocktails, and even the use of illegal narcotics. Although not all alternatives are necessarily dangerous, this category of pathography offers physicians valuable intelligence on practices that might merit discussion during follow-up visits with a patient who has visited such a site. At the very least, physicians would be remiss to not intermittently monitor sites offering these sorts of pathography narratives for insight into common or emerging trends in self-medicating, allowing them to be prepared to field questions by patients looking to such pathographies for second opinions.
- **Ecopathographies:** The final subgenre, the ecopathography, is perhaps the most rare. It is at once an exposition of a particular illness or disease, as well as an exposition of the social and historical complexities of that disease. In these pathographies, authors will often provide autobiographical information that goes well beyond the scope of the malady itself, and delves into the patient-author's family background or socioeconomic circumstances, using illness or disease as a metaphor for larger political statements. While "eco" is normally associated with environmental awareness initiatives, "ecological" actually

describes the complex cycles through which organisms interact with their environment. While now used in the context of reducing pollution and being environmentally responsible, the “eco” in this type of pathography denotes the way in which larger systems impact smaller ones with respect to health; for instance, the way in which a pathography describing a battle with irritable bowel syndrome (IBS) might serve as an essay or editorial on the use of genetically modified or overly processed foods in the Western diet. Beyond merely describing and documenting the symptoms of particular illnesses and diseases, this type of pathography is more centrally concerned with offering a social history of those same maladies, whether real or perceived, and doing so for a general interest online readership.

Both the medical humanities and digital humanities have their own collections of academic journals, online discussions forums, professional conferences and scholarly symposia, as well as a host of full-length books devoted to how these fields are changing the way people read, write, and acquire knowledge. Narrative medicine and pathography writing are arguably two of the most effective illustrations of how the digital humanities and medical humanities converge at the crossroads of technology, storytelling, and patient care. It is this departure from, yet also the appreciation of, medical science that also allows the medical humanities to appeal to broad scholarly and scientific interests while also reflecting the interests and experiences of everyday people—including patients. While there is not necessarily such a thing as a “good” or “bad” pathography, those authored for general interest audiences and that use accessible prose with limited academic or medical jargon tend to be the best represented and most read texts in terms of visitor traffic, comments, and social media activity based on search engine optimization (SEO) results. Conversely, while pathographies can make for effective reading material for healthcare practitioners and are a valuable source of intelligence on emerging trends and sentiments about the medical system, there are other online writing mechanisms, rooted in narrative, that remain limited to professionals, clinicians, and healthcare researchers in terms of who both the authors and target readers are.

MEDICAL BLOGGING

A medical blog is one example of how online pathography writing can complement other forms of healthcare writing designed for publication on the internet; at the same time, medical blogs also have a number of distinguishing features that clearly allow them to stand on their own. First, the term blog is an example of what is known as a truncation, and is the more common and pruned-down version of what was originally known as a web log (sometimes compounded as either web-log or weblog). Blogs vary greatly in length and style, but are distinct from pathographies in that most pathographies are published to open-access message boards, online chat groups, listservs, or discussion forums. While a blog could be a collection of separate pathographies published under a single private domain, in general blogs tend to be organized or categorized by general theme but offer a variety of different narrative structures.

Unlike message boards that are owned and operated by third parties, including medical periodicals, commercial websites, or interest/advocacy groups, blogs and their content are the intellectual property, and remain under the creative control, of what is usually a single author. Typically, this author will boast either formal credentials or life experience in the area for which she is writing. By cultivating ethos and establishing credibility, the objective of the author-as-blogger should be to attract readers and traffic to the site through an array of timely and relevant content, as well as effective and engaging prose. Pathographies can sometimes turn up in blog entries, with authors, not unlike in travel blogs and other sites committed to documenting journeys, using each new post as an update in a running narrative. The start-up costs and ongoing

writing effort required to keep a blog current, and more importantly the fact that it can initially be difficult to acquire regular readers outside designated public forums with existing regular visitors, can dissuade patients from using blogs as an outlet for their pathographic anecdotes. This is in part why, more commonly, blogs of a medical nature are written not by patients for patients but by professionals for other professionals.

A blog is a personal website where an author, or invited contributors which sometimes include guest authors, electronically publishes commentaries, essays, or factual material for a public readership. Many blogs focus on one genre or discipline (medicine, law, politics, business, et al.), while many have no prevailing area of focus whatsoever. Whether or not they focus on a specific type of content and cater to a specific audience, blogs are different from other forms of online publishing in that the blog owner and author (normally one and the same) maintains complete creative control over content. This differs even from public message boards and open-access forums where pathographies are now most frequently found, and where content is often vetted and comments moderated or edited by a third party maintaining the site, also known as a webmaster. In the case of blogging, the site's owner is usually the sole contributing author, editor-in-chief, and webmaster at once. Blogs are exceptional and increasingly popular for this very reason, in that seldom in history has any form of writing and publishing allowed authors to maintain complete creative and editorial control over their own work, even after it is published. While this distinguishing quality is seen by many as great opportunity, demonstrating the true value of blogging as an active form of writing and scholarship, there are some professional, legal, and ethical issues that have also arisen due to the fact that bloggers often fail to screen their own work as rigorously as they should prior to publishing it. With respect to medical blogging in particular, problems can often ensue with respect to comments and opinions being taken out of context. Such circumstances are rare but suggest that healthcare practitioners, who are frequently in the public eye, should think twice about what they are prepared to write and say publicly. There are, however, writing strategies that can allow medical professionals the opportunity of maintaining or contributing to an active blog while also maintaining proper decorum and professional restraint. One such strategy is what can simply be described as writing etiquette; or, in the context of online writing: netiquette.

Writing etiquette in the context of healthcare environments was discussed previously and in greater detail in [chapter 2](#) with respect to writing memoranda, letters, emails, and other forms of interpersonal correspondence, both online and offline. That said, interpersonal correspondence and electronic publishing often come to share some of the same principles of decorum and professionalism, and both the writing styles and readerships will often converge. In other words, simply because blogs do not have a specific or cited addressee or intended recipient, this does not liberate the author from the same expectations and obligations with respect to etiquette and professionalism as found in more conventional and traditional forms of writing.

Also, because blogs can explore a wide array of topics, even within a specific genre of blog or when catering to a specific profession or readership, there is a wide array of writing styles available. Medical bloggers, like all bloggers, can adopt or experiment with a variety of registers as a blog develops new content and readers, adjusting their content and style of prose according to whom they determine, based on site metrics or comments, is their core or primary readership. For instance, personal blogs represent a category of blog writing where content is often intentionally devoid of technical or procedural material, and where the narratives serve largely as a public diary or as an assemblage of memoirs. Authors composing personal blogs frequently defer to using narration or description, and do not necessarily endeavour to impart any specific theme or thesis to a given piece, or even collection of pieces, and which are often little more than an ongoing stream of consciousness split into separate entries. Alternatively, professional or organizational blogs are slightly more focused in content and typically have discernible objectives and theses. Not surprisingly, it is into this category that most medical blogs fit.

The **blogosphere**, a term that describes the world of blogs and its users, to some extent operates as its own internet, with bloggers linking sites and content to allow for seamless navigation between blogs. With nearly one million new blog posts being posted daily, these interconnections can prove significant in redirecting both individual readers and entire waves of internet traffic to specific sites or links, in part determining how online phenomena like viral videos and internet memes are distributed and disseminated. The blogosphere is therefore best conceptualized as a network of blogs that engage with not only other blogs but also social media tools, the latter also being of interest to healthcare writers, as detailed in the [next chapter](#). With respect to blog writing in particular, the blogosphere can be subdivided into separate nodes where blogs, typically of a professional nature, and boasting relatively specific or arcane content, have dedicated followers rather than just random surfers browsing general interest content.

Medical blogs represent some of the more specialized blogs within the cybermedicine model and have an intended, targeted readership that usually includes medical professionals and other **highly qualified personnel**. They tend to not contain pathographies but are instead conduits for professional exchange and dialogue, inviting comments and feedback from visitors. As such, medical blogs tend to be didactic, or teaching narratives where some type of professional lesson or learning objective is advanced through a healthcare case study, anecdote, or observation of the author or contributor. Often described as “creative research,” medical blogs represent an innovative method of disseminating relevant clinical and collegial information in a less formal, open-access format—yet one that often retains the style and content of what might be found in a medical journal article or published study. While key medical journals such as the *New England Journal of Medicine* and the *Lancet* have multiple contributors in each edition and the submissions are rigorously peer-reviewed, medical blogs are comparatively self-managed solitary ventures. Peer-reviewed scientific journals are also graded in terms of relevance and professional importance through what is known as an **impact factor**, or the metrics used to quantify how frequently articles appearing in a given journal are cited elsewhere in other research papers and by whom.

As a general rule, the higher the impact factor, the more sought after and prestigious a select journal is among healthcare researchers and authors. Those higher-ranking journals in terms of impact factor consequently tend to also receive a greater number of submissions, and publishing with these outlets is highly competitive. Medical blogs have, however, in much the same fashion that electronic publishing and e-books have enabled authors of any genre to circumvent traditional publishing houses and arduous manuscript submission processes, allowed healthcare professionals an alternate mechanism for disseminating their written work. This is not to say that medical blogs are replacing conventional journal article publishing by any means. Medical blogs instead serve as a less restrictive extension of journal article writing, with the objective still often being to advance a specific hypothesis, conduct a meta-analysis, or impart information and insight that will assist in professional development, but wherein the author maintains sole discretion over content, as well as complete control over the topics discussed, editorial decisions made, and copyrights.

The medical blog [EMCrit.org](#) is an effective illustration of how blogging can simultaneously fulfill a number of professional competencies while also establishing medical practitioners as writers. At once an example of medical education, of the type of cathartic writing seen in parallel charting and portfolio as the distillate of narrative medicine, and finally of the way that cybermedicine has enabled new forms of information delivery and publishing, medical blogs such as this underscore how, because clinicians and practitioners are professionals who write and publish (whether through FIO disclosure or deliberate publication), they might as well maintain some control over their compendium of work in the public eye. As a crucible of stories, studies, and resources, [EMCrit.org](#) is a site that by name and branding is targeted toward a specific

readership, with the rhetorical modes and registers used in the writing being nuanced to suit the expectations of the audience.

Like most professional blogs, its title is consistent across both the headline banner and the universal resource locator (URL), suggesting that committing to a name for a blog and considering how that name reflects the material covered therein are two of the first objectives of would-be medical bloggers. Whenever possible, the name of the blog and the associated URL should be as closely matched as possible. Even before the writing begins and the rhetorical design of the site becomes a consideration, selecting a suitably representative title should therefore rank as a priority. Most domain name providers allow URLs to be searched free of charge, allowing would-be medical bloggers the opportunity to see what website names are still available for purchase. At this same time, there should be some consideration with respect to the URL extension (.com, .ca, .net, .org, etc.) and how these extensions might serve to brand the blog, help control web traffic, and even cultivate ethos. In other words, before the writing process even begins, there are a host of rhetorical decisions that need to be made with respect to the titling and branding of the blog as a text, even before content is populated.

This start-up process is both creative and strategic, and it requires some level of commitment by bloggers to a given topic and title alike, especially given that the URL should ideally not change over time, and redirecting or [pointing](#) to other blogs with different names should be kept to a minimum. Certainly, as a given blog evolves and acquires additional content, other domain names and URL extensions may be acquired and used to point back to the primary site, or away from the original site to new content; however, in conceptualizing a blog, medical or otherwise, some due diligence should be used in selecting a URL that offers long-term stability. A URL should be selected with the view that it will not only serve as the site's title, but also help shape the user experience of the site by extension, including the experience of writers contributing narrative content.

EMCrit Blog

A Discussion of the Practice of ED Critical Care



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Get Updates!

Check with your email client for more information.

Wee – What the heck is a Mapleson B Circuit and Why You Probably Shouldn't Care



There is a really smart anesthesiologist out there called Nicholas Chrimes. He along with his mate Peter Prits invented the Vortex Approach to Airway Management. He also runs a blog called Clinical CrEd. He did a post advocating the Mapleson B Circuit as the Ultimate Preox Device What is the Mapleson B? The Mapleson circuits were [...]

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SEARCH

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Search

- Ring menu contains metaphorical writing and liberal use of acronyms that reflects the dialect of the readership.
- Social media widgets allow readers to share the site with other prospective readers.
- Site contains a clear title that matches the site's URL, along with a subtitle that delineates the content.
- Rhetorical question establishes a consultative, less formal register and prompts readers to evaluate the relevance of the site to their work.
- Bulleted points highlight objectives of the blog and establish the style of the writing.
- Provocative headline statements allow the site to bridge both scholarly and opinion-editorial styles of published writing.

Beyond the home page of a medical blog, which serves as a site's public face, the wording of the ring menu is important in terms of keeping visitors on the page. Each item listed in the menu, known as menu items or menu options, may be standalone links to specific pages and written content, or can offer additional options by way of a dropdown menu or some other suite of subcategories. For optimal navigation experience and ease of finding the desired written content, especially with respect to browsers on mobile devices, these subcategories need not be overly detailed. In the interest of both clarity and editorial purposes they should be single words, acronyms, initialisms, or simple combinations of words that readers, familiar with the content and register being used, will immediately recognize. Again, because medical blogs are designed not for laypersons, as in the case of many commercial websites or pathography sites, but for a comparatively professional audience, medical bloggers can revert to using a professional **nomenclature** in much the same way they would in a care-delivery environment. Once the desired menu selections are made by the reader and she is directed to the appropriate page, a medical blog becomes less about format and style and more about substance and offering specific data; the author(s) are consequently expected to deliver narratives that are informative and advance discussion in a particular area of relevance to the bloggers and the readers alike. At the same time, medical bloggers have the advantage as writers of being able to exercise tremendous creative latitude when it comes to the style of prose used, and can blend any number of clinical and commercial writing styles to make the content accessible and enjoyable, at least as compared to more pedantic texts that practitioners are frequently accustomed to reading as part of their

initial education, as well as their ongoing training and professional development. A hallmark of most effective medical blogs is that they are able to deliver technical material (exposition) but do so by using a lighter type of language and often by interjecting personal anecdotes (narration).



Under the ‘Procedures’ menu option, visitors find a number of technical terms that may only be recognizable to targeted readers, such as DSI (delayed sequence intubation) and CVP (central venous pressure). While excluding casual or non-clinical readers, these lexical distinctions are key in attracting the desired readers for whom the content is written, and in cultivating ethos on the site.

Beyond the surface structure of the blog and its suite of menu options, as well as any graphic treatments or other links that might be embedded in a particular blog, is the substantive content that makes a blog what it is—an electronic narrative or collection of narratives in earnest. Each one of these narratives is what is known as a blog entry, written as a combination of exposition and any number of other rhetorical modes, depending on the scope of the entry. Drawing on periodical and academic journal styles—both of which as a general rule use the American Psychological Association (APA) citation and editing style covered in [chapter 8](#)—blog entries typically have a header or title, as well as subheadings that serve to delineate the narrative into coherent and distinct sections for easier navigation. The use of subheadings also allows readers landing on a blog, or requesting a blog entry page from a server for the first time, to establish a cursory overview of the piece and the themes explored therein. From a writing perspective, the use of subheadings also allows bloggers to blueprint their narratives before delving into the composition process, and can prove especially effective in terms of organization and time management when creating rough outlines. Subheadings can also assist in establishing editorial controls on the length of a given piece, breaking it up into sections that can each be independently edited prior to publication.

The Case

You have a 50 y/o male with bad bilateral pneumonia. BP 108/70, HR 96, RR 28. He is delirious, agitated, and looks sick, sick, sick! Saturation is 70% on a nasal cannula; when you try to place the patient on a non-rebreather (NRB) he just swats your hand away and rips off the mask. It is obvious to everyone in the room that this patient needs intubation, but the question is how are you going to do it?

Your first impulse may be to perform RSI, maybe with some bagging during the paralysis period. This is essentially a gamble. If you have first pass success, you (and your patient) may just luck out, allowing you to get the tube in and start ventilation before critical desaturation and the resultant hemodynamic instability. However, the odds are against you: bagging during RSI predisposes to aspiration, conventional BVM without a PEEP valve is unlikely to raise the saturation in this shunted patient, and if there is any difficulty in first-pass tube placement your patient will be in a very bad place.

A Better Way

Sometimes patients like this one, who desperately require preoxygenation will impede its provision. Hypoxia and hypercapnia can lead to delirium, causing these patients to rip off their NRB or non-invasive ventilation (NIV) masks. This delirium, combined with the low oxygen desaturation on the monitor, often leads to precipitous attempts at intubation without adequate preoxygenation.

Standard RSI consists of the simultaneous administration of a sedative and a paralytic agent and the provision of no ventilations until after endotracheal intubation (1). This sequence can be broken to allow for adequate preoxygenation without risking gastric insufflation or aspiration; we call this method “delayed sequence intubation” (DSI). DSI consists of the administration of specific sedative agents, which do not blunt spontaneous ventilations or airway reflexes; followed by a period of preoxygenation before

- Title of piece is casual but declarative in its wording and re-establishes the initialism that forms the basis for the entry, i.e., DSI.
- Subheadings are bolded and left-aligned to match the format of the title.
- Prose is expository and scientifically rigorous, but employs elements of narration and description and is increasingly casual as the narrative progresses. This includes the author-blogger using hyperbolic punctuation and word patterns (i.e., sick, sick, sick!) that create levity within the piece. Such tactics would not normally be permissible in other types of medical writing, but are entirely appropriate in the context of this blog.

Effectively written medical blogs of this nature allow clinicians and healthcare professionals to engage with other professionals, exchange ideas, and advocate specific research or care-delivery models in an open and less formal—but no less credible—forum. Medical blogs are as much about networking and showcasing the work done by a specific practitioner, healthcare group, or care-delivery institution for a wider global audience as they are publishing in the traditional sense. As a blend of journal-style research and exposition, as well as magazine-style popular science combined with elements of narrative medicine, medical blogs offer great latitude in terms of rhetorical modes and allow for the blending of multiple genres and registers. Beyond the craft of synthesizing these disparate writing styles to maximize the relevance and appeal of a given medical blog, there are additionally other strategic writing and syntactic decisions that medical bloggers can draw on to maximize the exposure their work receives.

Blogging, medical or otherwise, is often an end in itself for many practitioner-writers. Not unlike parallel charting, it can frequently serve a cathartic process, or can simply be used as evidence of additional research, scholarship, and community engagement for professional

advancement purposes. However, given the specificity of the content and target readership, medical blogs are most useful if they actually get read. Not unlike the way that an impact factor can determine the relevance of a given peer-reviewed journal, there are similar metrics that can be used to determine the reach of a medical blog, and therefore function as a proxy of both its popularity and importance. Website analytics, or the patterns reflecting visitor data in relation to a specific blog, or pages within blogs, are generally considered the best indicator of internet traffic and how to measure reader interest; this includes data relating to not only the total number of visitors and average visit time to a site or page, including the percentage of visitors who land on a blog and then immediately leave (bounce rate), but also the percentage of visitors who leave the site from a specific departure point or section of the blog (exit rate). Analytics also yield rich data that reflects not so much the appeal of the written content to a public audience, but more demographic information about the readership, including country or area of origin, and technical information such as the web browsers or search engines being used to refer visitors to a blog. Generally speaking, this data is not made publicly available and is intended for private review by a blog's author, administrator, or webmaster as a means of gauging the effectiveness of content and reader-visitor behaviour. In terms of the editorial decisions made by bloggers in maintaining control over content, there are specific lexical distinctions—or strategic word choices—that as part of the writing process can be used to enhance the exposure of a given blog and ensure that traffic to the site is maximized. Unlike journal and magazine writing in the health sciences, medical bloggers have the opportunity to exploit the medium in which they write in order to engineer a wider readership. By using effective wording strategies in not only the narrative content of the blog itself, but also in the indexing of the site, medical bloggers can maximize the blog equivalent of a high impact factor: unique visitors.

In assessing the relevance of a blog and when assessing web traffic analytics generally, **unique visitors** are the distinct, individual users who click on to a webpage directly or are referred there from another source. Unique visitors are the best proxy for website traffic and content relevance and popularity because they reflect new or returning visitors, but are tracked separately from the total number of visits. In other words, ten unique visitors each clicking on to a blog once per day is considered a better indicator of a site's readership—and is generally considered preferable—than a single unique visitor clicking on to the site ten times a day. In order to attract the greatest number of unique visitors, a blog, like any site, should use what are known as search engine optimization (SEO) strategies that will boost a blog's ranking and visibility in web browser fields when certain search terms are used. SEO strategies and tactics at the coding level can get extraordinarily complex in terms of coding and scripting strategies, and while historically used for marketing purposes and to—as the name suggests—optimize a website's position on a results page following a basic search using any search engine (Google, Bing, Yahoo, etc.), bloggers are now adopting SEO methods to ensure consistent exposure in the increasingly crowded blogosphere. In looking once again at the loose connection between peer-reviewed journals and medical blogs as mutually relevant forms of publication among healthcare professionals, SEO methods in the context of medical blogging are not dissimilar to one of the hallmarks of effective journal article writing: keyword indexing.

In journal publishing, **keywords** describe any limited set of words that are selected for use in indexing articles; the same strategy can also be used to ensure the best SEO results in medical blogging. Whether in journals or blogs, keywords are carefully selected words—often drawn from a prepopulated list in the case of some journals—that are representative of the material covered in any piece of writing, or that emphasize or illustrate a central theme. In journal pieces, keywords typically follow the **abstract**, or synopsis of the study being presented at the beginning of an article or study, and can number anywhere from four to six. Scholarly writing in healthcare, including composing journal pieces and abstracts, is discussed ahead in **chapter 8**; however, in discussing medical blogs and how SEO requires that writers judiciously select representative

words to strategically maximize the exposure—and by extension the audience—of a blog, it is worth noting that effective keyword selection is fundamentally similar across both writing platforms.

While journal article keywords are used for indexing purposes and typically hover around the four- to six-word mark, SEO keywords tend to be greater in total number, as well as in the way individual words can be combined. While the methods used for indexing SEO keywords vary by the platform, web plugin, or sitemap being used, having a list of important words prepared ahead of launching a medical blog can expedite the publishing and SEO processes and help ensure the blog attracts a greater number of readers. By brainstorming and listing up to ten keyword combinations on a basic word-processed document for use in SEO indexing later, bloggers can help create the roadmap that will lead web traffic to their site and maximize readership based simply on the design of web browsers.

For instance, consider a medical blog featuring narratives about same-day appointment primary care clinics, and which targets physicians, nurses, and clinicians working in general practices as its primary audience. Some SEO keywords that might assist in attracting targeted readers conducting research on this trend, or practitioners considering adopting a same-day appointment model for their own clinics, might include the following word combinations:

medical clinic, medical appointments, same-day appointments, same-day clinics

In addition to this battery of overlapping words and ideas, it can be useful to include location-specific words, such as the country, province or state, or county. Integrating these location words among the SEO keywords in medical blogs may depend on the intended geographic scope of the blog or its targeted readership; however, what are known as vanity words, such as the name of the author, the name of the clinic or practice, and the specific address of the practice should generally be avoided as, at least initially, users will not be searching by proper name and will likely be using more generalized search terms. Because a blog is intended to disseminate information and enable professional connections, vanity words also don't generally assist in attracting a professional readership or following, and tend to be reserved for web pages that are intended to function as advertisements for specific products or people with immediately recognizable names.

medical cl|
medical clinic
medical clinics ottawa
medical clinics toronto
medical clinic barrhaven

Current web browser search fields can be a useful resource for identifying popular or prevalent extensions of search words or strings, and can help identify logical SEO keywords for bloggers.

In shortlisting a collection of SEO keywords, it is helpful for authors and medical bloggers to conceptualize how they themselves exhibit HSIBs and might browse for information or literature on a particular topic covered by the blog. This requires that medical bloggers anticipate or make educated guesses with respect to what the most likely words used by both professionals and laypersons might be in searching for particular information, and then adjust their list of keywords to reflect this. Additionally, the current version of the internet, known as the semantic web, and the way in which browsers anticipate words based on recent or popular searches by area can be a useful research tool for bloggers in determining what words are most frequently used and where. By simply entering partial words in a web browser's search field, bloggers can use the anticipated results to strategize what SEO keywords can link their blog to popular searches.

SEO keywords that can assist in attracting targeted, professional readers should not only reflect popular internet searches as indicated by semantic web search data integration, but should also be cross-referenced to the actual narrative content of the blog itself. For instance, if an SEO keyword includes the word “clinic” used in combination with other words, it should stand to reason that this same word should appear in some form on one or more of the blog’s pages. There is in fact an additional compositional strategy that can be used to link SEO keywords to blogs and then also to specific pages and sections of page within the blogs themselves. This phenomenon, known as keyword density, includes the number of times one or more of the SEO keywords appears *verbatim*, or precisely as written elsewhere, within a given page or entry on a blog. While there is no specific, arbitrary number that is necessarily considered optimal in terms of keyword density, the general consensus among internet strategists and web designers is that bloggers should aim to have a range of anywhere from one to five instances where SEO keywords appear on each page of the blog itself. Under most circumstances this number should unfold intuitively and without great effort, as there should be a natural pairing between keywords and the actual written content found in the blog.

As strategic as medical blogging has become in terms of directing web traffic and attracting readers, and in spite of the growing number of academically and scientifically diligent blogs that advance discussion, debate, and research in specific areas of healthcare, it is not without its potential problems. With the growing number of healthcare blogs and ever-increasing number of freelance medical writers appearing in public dialogues, a recent trend has emerged that raises concerns about professionalism in electronic writing among healthcare practitioners. Not unlike how countless stories have come to pervade the media describing how online indiscretions or emails and social media posts made on impulse have come to get the writers into personal or professional trouble, so too does medical blogging present potential issues of liability—not only direct liability for the author, but also potential third-party liability for healthcare institutions.

Once again, the nexus between blogs and more traditional journals has led to professional and interpersonal conflict among bloggers who—while no doubt being effective writers in many cases—have failed to properly recognize the reader expectations, operating registers, and HISBs of the primary audience of most medical blogs posted to the internet. With the commercial media and even medical associations representing the collective interests of healthcare providers having recently published disconcerting stories of practitioners using their medical blogs to publicly offer opinions about hospital policies and even complain about colleagues and patients—in some cases breaching physician–patient confidentiality—medical blogs do pose some element of professional risk for clinicians perhaps accustomed to writing in other professional forums. Unlike academic and scientific journals, for instance, where submissions undergo rigorous screening, review, vetting, and editing, blog entries can be written in haste or in anger and published to the web, where a permanent electronic record is soon established. The act of writing and publishing as a linear, fluid process in medical blogging means that healthcare practitioners, as professionals dealing with the public, trusted by the public and continuously in the public eye, are expected to conform to certain behaviours, even in their blogs and online lives—*especially* in their online lives. The key to effective and responsible medical blogging is therefore to advance new ideas or topics for debate or analysis, while exercising discretion and good common sense.

HEALTHCARE WIKIS

Electronically mediated healthcare narratives are in many ways just a new way of composing and cataloguing—and in some cases circulating—pre-existing types of medical writing. Just as the medical blog is the indirect descendent of the medical journal article, so too is the healthcare wiki an approximation of the same type of anthological writing seen in patient charting, where multiple contributors co-author a collection of individual documents. A healthcare wiki also

draws on the successes of medical blogging as an outreach initiative enabled by the connectivity of the internet, and can be best described as an electronic medical anthology where a number of practitioners collaborate on and co-author content on a single website. Unlike a blog, which typically has a single author or small number of regular authors, or a pathography found on a general interest site where HISBs can be expressed by way of public dialogue and message boards, wikis fall into an electronic writing category all their own.

A **wiki** is, simply put, any open-source, web-based application that allows for multiple authors to modify or improve content. That said, “open source” does not mean that, unlike a HISB general interest site, that just anyone can be a contributing author. One part database administrator and one part narrative author, being a wiki author or editor usually requires approved registration. This in theory ensures some measure of quality control over who is permitted to modify content. These types of authorship control are not so much an attempt to make wiki writing exclusive or elitist, but rather, to cultivate ethos in the final product by ensuring a wiki’s contributors have appropriate expertise and writing ability, thereby ensuring their contributions are meaningful and appropriately sourced. In some sense, wikis actually represent the most democratic form of writing and knowledge mobilization on the internet, with multiple contributors working together and changing the form and content of documents through consensus and collaboration.

Given the scope of many healthcare wiki sites and the number of active writers, editors, and contributors with any one site, wikis also tend to be larger in their scale than other electronic medical narratives, including online pathographies and blogs. In fact, the term wiki—largely as a result of the cultural importance of Wikipedia as an information management system and go-to resource for nearly all topics—has come to be associated by the general public with encyclopedia content. Healthcare wikis similarly serve as reference materials and approximate the design and functionality of encyclopedias in that they have multiple contributors and arrange written entries as part of a larger compendium while using what is often called a **reference format**. The main distinction between reference format and other writing formats is that reference works contain only verifiable, confirmed facts, and tend to be organized and compiled in brief passages rather than in lengthy monographs. These passages are often organized alphabetically or by specific category of information—sometimes both—and despite being brief and intended for quick reference, they are nonetheless expected to use proper narrative prose and coherent sentences. In fact, the key distinction between wikis and other forms of healthcare writing online is that, like analogue notes made in the care-delivery environment, wiki writing is purely expository in nature. It is therefore not the brevity of the entries as much as the rhetoric mode—and consistently formal register—used in the writing that distinguishes wikis.

Most healthcare wikis as a general rule tend to be either specialized in their content (focused on a specific disease, disability, medication, or even body part or organ) or are instead generalized in terms of readers being able to pose questions and receive responses from accredited experts in the related field of medicine. In the latter case, the exposition used in wiki writing takes on a somewhat consultative nature, in that wiki writers are actually responding to prompts facilitated by HISBs, although the responses typically amount to a one-time exchange as opposed to other instances of consultative writing and communication that are more fluid.

In addition to offering both medical practitioners and the public alike a credible forum where questions not reasonably addressed in other electronic narratives can be addressed, or where a central repository of information for professionals is lacking, healthcare wikis are also of significance to medical librarianship and information cataloguing as two adjuncts of healthcare writing. Health sciences librarianship and wikis are actually closely connected extensions of cybermedicine. Given the way that the federal government in Canada has been recently divesting itself of publicly held archives, including the Health Canada library that is now considered to be in a “reprehensible state” (CHLA, 2014), public wikis may indeed represent the future of medical archive custodianship and data warehousing. Wikis, as more than just reference sources and

forums for professional collaboration among healthcare writers, may actually be the last hope for sustainable medical record keeping outside of hospitals. The recent spate of courses offered at the university graduate level, and at the vocational college level, encompassing health records information management and ehealth library sciences would certainly suggest that the medical library of the future rests within the wiki community.

Beyond the theory of healthcare wikis and what they offer the practice of medicine and healthcare informatics is the actual practice of composing and editing wiki entries. Generally speaking, any approved contributors who are tasked with coding and information security are also expected to contribute to the sustainability of the wiki in some fashion. This might include responding to public enquiries or moderating questions, or writing discipline-specific content within one's professional purview as a wiki's contents expand and evolve. As these entries are expository in nature and comparatively succinct in their length in comparison to other types of cybermedical writing, editing at source and writing with concision are once again key in making each entry accessible to readers. Striking a balance between full, reliably sourced information, and clear and concise prose is ultimately the objective in wiki writing as its own distinct subgenre of healthcare communication. The fact that wikis are also open source in nature, as well as rewritable and editable by design, ensures that those wikis that fail to meet generally approved writing standards may be revised, edited, or amended by other authors without notification.

Stem Cells [edit]

The growth of stem cells in the bone marrow is the basis for cellular immunity. In vitro mimicry of this growth can be achieved by filling a semisolid medium with stromal cells. By adding different growth factors and cytokines, as well as stem cells of various differentiation level, the influence of chemical mediators of hematopoiesis can be understood. HSCs can be taken from a donor and injected into a person who has a defective or absent hematopoietic system. As little as 10% of the donor's bone marrow is removed and injected into the recipient, and the HSCs will find their way to the bone without direction, replenishing the hematopoietic system of the recipient. There are several types of stem cell grafts:

- autologous--donor is the recipient themselves; the recipient can freeze HSCs prior to chemotherapy or radiation therapy for cancer; additionally, genetically engineered autologous HSCs can be injected back into the patient
- syngeneic--donor is genetically identical to recipient (identical twins)
- allogeneic--donor is genetically different from recipient
 - this can lead to graft-vs.-host disease (GVHD)
 - GVHD is based on MHC/HLA types, and so a bone marrow "match" occurs when an allogeneic member of the population is found to have relatively similar MHC/HLA types relative to the recipient

- Title of piece with corresponding editing link that allows for modification of entire entry. Title should have no subtitle.
- Topic sentence is a simple sentence as defined. Transition sentences use specific nomenclature and relevant statistical data to set up the point-form list that follows.
- Clarifying data written in points and itemized with bullets in order to avoid lengthy narrative sections. Supplemental information listed in parentheses.

This sample is not necessarily representative of all wiki entries, many of which will vary greatly in length and detail depending on the generality or specificity of the entry. This sample is,

however, certainly an effective referent for the formatting of healthcare wiki narratives generally. Defined by clear, single-clause titles with no subtitles; concise and direct topic sentences, and transition sentences that are normally simple or compound sentences as defined (see [chapter 6](#)); and tables, indexes, graphs, and other breakdowns of complex data that are more clearly conveyed as bullet points or in graphic form rather than narrative prose, wiki entries are more formal and succinct than blog entries, but frequently overlap in terms of readership. Reprising what we discussed in [chapter 1](#) about the medium in which a narrative is written shaping the content of the narrative itself, it is important to note that while healthcare wikis and blogs are both examples of cybermedicine and frequently have the same target audience, there is very seldom crossover in terms of the actual writing style, nor is there generally any overlap in terms of the online platforms where they are be found.

Healthcare wikis are to some extent, by virtue of their collaborative nature and immediately accessible design to both practitioners and laypersons, an example of what is known as public health. The term [public health](#) denotes a broad concept that describes the way that specific campaigns, technologies, or initiatives can be used to bring the public and medical professionals into common dialogue and promote awareness. Public health as both a practice and an idea is intended to bridge private and public debates about health education and reform, disease prevention, and enable innovative and collaborative approaches to ensuring the holistic well-being of entire populations. In the following chapter, we continue on with our examination of public health and the way that healthcare writers can learn from and actively contribute to a growing public health discourse through new and emerging media technologies. In moving from pathographies, blogs, and wikis—all of which are versions of cybermedicine that have established roots on the internet—we move to examining the special considerations for healthcare writers authoring materials for social media. It is a forum still not entirely accepted by all healthcare providers or practitioners as a legitimate publishing resource, but it is one whose cultural imprint and global influence in the context of public health and knowledge mobilization cannot be overstated.

CHAPTER SUMMARY

By this point, you should be able to:

- Differentiate between telemedicine, ehealth, and cybermedicine, and what writing strategies might be employed for each.
- Understand how pathography writing has evolved over the last several decades in terms of authors, audiences, and subject matter, up to its current form as a subgenre of writing for cybermedicine. This includes the ability to differentiate between its four online categories: the didactic pathography, the angry pathography, the alternative pathography, and the ecopathography.
- Discuss why it might be valuable for healthcare professionals, even if they aren't contributing the online body of pathography writings, to monitor content so they are aware of current trends in patient narratives and what some forums may be advocating as alternative forms of care.
- Define cyberchondria and explain how online healthcare narratives like pathographies can serve a valuable role in self-diagnosis and pre-screening, but can also lead to exaggerated or unfounded fears of disease and place additional burdens on the healthcare system.

Some self-check or class discussion exercises you might want to try include the following:

- Select a medical blog of your choosing or in your area of interest with respect to healthcare and examine the writing style. What is the prevailing rhetorical mode? What register is the author-blogger using to engage the audience? Is the title and content of the blog engaging and rhetorically effective?
- Conduct your own crowdsourcing experiment with the semantic web by opening a popular browser like Google and typing the first few characters of some common healthcare-related terms. What does the browser fill in or anticipate you're trying to search for? How can the automated prompts be used to tell healthcare professionals something about common interests and concerns about medicine and patient delivery among the general public? Are these the types of concerns that should be responded to in a professional medical blog?
- Have a look at some healthcare wikis and take note of the writing style along with the related rules or online community standards. What is required in order to post or edit a submission? Are there related terms of use or editorial guidelines that suggest that healthcare wiki writing is perhaps very different from other forms of writing for cybermedicine?
- Create a list of keywords that you have used or would want to use as SEO terms when indexing a medical or professional blog of your own. If you had to pick just ten words that would summarize your blog, appear regularly in your writing, and also help connect you with your target audience through common search terms, what would those words be?

For healthcare practitioners and writers alike, social media offers both pitfalls and great opportunities—both personally and professionally. As perhaps the hallmark of the semantic web, social media has forever changed the way that information is rapidly disseminated, ideas are endorsed or advertised, and people connected. Like comparatively unrestrained forms of blogging that fail to respect, for example, privacy and copyright law, social media posts made in haste or anger by clinicians who interact with the public and who serve as the public face of hospitals and the healthcare system as a whole can prove extremely problematic in terms of damage to reputation. Questionable posts to social media sites can also lead to formal discipline or sanctions by governing bodies, as well as litigation and even dismissal. It goes without saying that all elements of healthcare intrinsically contain some element of risk, just as all elements of good writing do—the frequently “viral” immediacy of and massive readership imparted by social media publishing only intensify those risks. The key to being an effective writer or practitioner, let alone a practitioner who also writes, is therefore not necessarily to be risk averse as much as adept at risk management. The good news is that writing for social media used effectively can, especially in the context of healthcare, rapidly and accessibly increase awareness, education, and reputation like few other platforms.

In its early years, social media was generally considered a novelty or a distraction by most healthcare or government employers, and even a security risk and blight on one’s professional reputation. Today, many of these same suppositions prevail, with many employers—usually hospitals or other government-affiliated buildings—having taken steps to firewall or otherwise block access to social media sites in the workplace; this, in spite of the prevalence of smartphones and other devices that can circumvent the employer’s server and access these same sites more discreetly. While efforts have been made to limit the degree to which social media activity penetrates the workplace, a number of institutions have also acknowledged the reality that social media is now a necessary tool that, when managed effectively, serves an invaluable role in public relations.

While the pros and cons of social media use in the context of healthcare likely merits a book in itself, this chapter is more specifically concerned with how medical practitioners and healthcare professionals of various backgrounds, specialties, and employment arrangements can use social media as a conduit for improving and developing their skills as writers, as well as how social media can be used as a knowledge mobilization and publishing outlet for more experienced healthcare writers looking to diversify their targeted readership. Like blogging, healthcare writing that uses social media as its writing surface will have its content shaped by the architecture of the platform being used to compose the narrative—narratives that like other forms of electronic composition will inevitably draw on both exposition and any number of other rhetorical modes. Like medical blogging, the linguistic registers used in social media writing—even when serving as an outlet for “official” statements disseminated by executive administrations or on behalf of institutions—tend to defer to the prevailing linguistic culture of the medium rather than the offline culture of the institution itself. This is in part a reflection of the way in which the stylistic and editorial controls placed on social media writing ultimately require that all genres of writing

—healthcare, legal, technical, political—defer to a common register. This is a register that, contrary to most of the types of healthcare writing and prose explored in this book, is more promotional than procedural.

Health promotion is a complex term—an even more complex concept—with connections to public health but likely best described as health education combined with social marketing (Bunton & MacDonald, 2002). In brief, health promotion describes efforts undertaken by both groups and individuals, including practitioners, educators, medical institutions and their executives, as well as charitable groups and grassroots organizations, with respect to raising awareness about specific health concerns. In some cases, health promotion can be used to describe efforts undertaken to solicit donations to accredited health research or care organizations, though the term is typically limited to organizations that are tasked with healthcare delivery or disease prevention. Covering topics and timely issues ranging from exercise and fitness to smoking cessation, workplace safety, food safety, and programs relating to the prevention of sexually transmitted diseases, health promotion is about assisting people in making informed decisions about health and wellness. This “promotion” in turn requires accessible and socially relevant mechanisms for delivering this information, and nearly all promotional efforts require some degree of specialized written content.

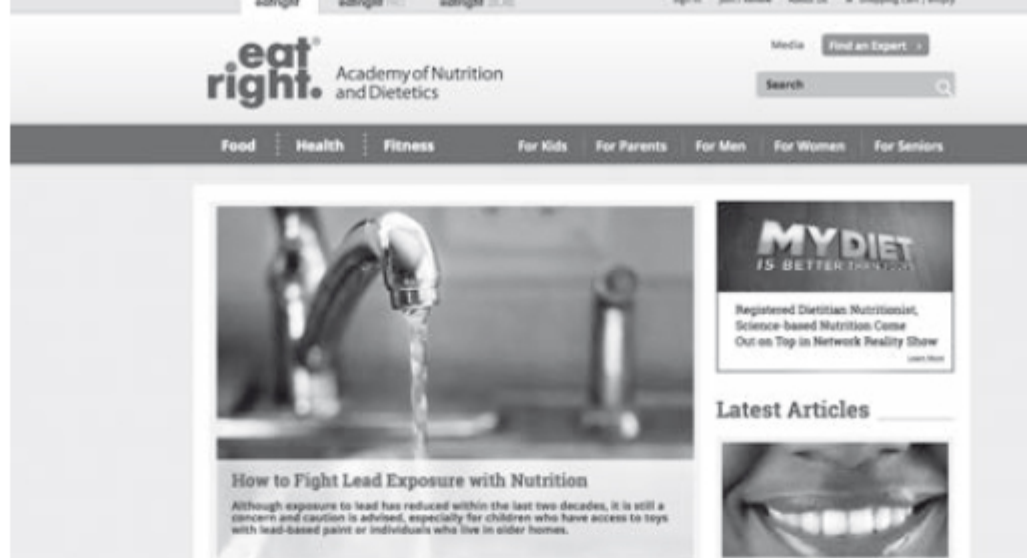
In some cases, official healthcare groups, even multinational groups such as the World Health Organization (WHO), the Pan American Health Organization (PAHO), and the International Union for Health Promotion and Education (IUHP) will host conferences or publish what is sometimes known as “grey literature” that encompasses health promotional content. As the name suggests, **grey literature** represents a similarly “grey” area of writing and publishing in which both government and nongovernmental organizations (NGOs) may compose and release reports relating to healthcare policies that ultimately make their way to government bodies for review, but which have no confirmed first published origin. Unlike most published documents or records that have verifiable primary and secondary authors, dates of issuance or copyright, and other key pieces of information readily available to allow for everything from library cataloguing to confirming the **provenance** or continuity of a piece of writing, grey literature describes reports that often use back channels before surfacing in the public eye or in government sessions months or years later.

The internet, beyond the scope of social media, has further complicated the itinerary of grey documents to the point that health reports can sometimes **leak** to the public sphere via various online portals, and can be read without context or appreciation for the motivation behind the writing process. Perhaps in response to the way in which the internet has changed the delivery of official promotional content, and as a means of ensuring quality control over the content itself, healthcare institutions and even provincial and federal government bodies have responded by creating specific divisions whose purpose is to control the flow of health promotional content on the internet, and to serve as the go-to authority on such matters. In the United States, for example, the American Public Health Association (APHA) dates to 1872, but has more recently created a new Public Health Education and Health Promotion division that boasts a significant online presence complete with links to policies and newsletter materials. Similarly, since the emergence of the semantic web, the Royal Society of Public Health was formed in 2008, and in Canada, the Government of Ontario created the Ministry of Health Promotion and Sport even earlier, in 2005. Ontario’s new ministry, as with all ministries, also required the appointment of a Health Promotion Minister to regulate and oversee the authorship and delivery of health promotion materials. By 2011, the ministry was merged with the Ministry of Health and Long-Term Care to avoid duplication, and with the understanding that healthcare, health promotion, and information on care options are all mutually inclusive phenomena.

Beyond serving as a resource on health management and illness prevention, the Ministry of Health Promotion and Sport, as well as the current Ministry of Health and Long-Term Care with

which it was amalgamated also fund other NGOs that use the internet as their primary publishing resource. These groups include the Eat Right Ontario Service, an online resource for food safety, nutrition, and weight management. This outsourcing of written content to third parties able to exercise their own creative controls with respect to prose, registers, and other integrated media content (text and graphics) foreshadowed the way in which social media would come to supplement and complement official government web materials. These materials largely include health promotion content, which has in turn led to the emergence of health promotional writing as its own subgenre within the paradigm of healthcare prose. It is a subgenre that is grounded in narrative and which is written, unlike other forms of cybermedicine, not by professionals for professionals, but by professionals for laypersons—a distinction that has an impact on both the choices of register and rhetorical modes used in the writing, and satisfies the need to make often complex medical processes widely understandable.

The format used by Eat Right Ontario as a subsidized online resource for health promotional information represents an alloy of various other styles of electronic healthcare prose; specifically, one finds the concision and editing techniques used in healthcare wikis, the informality and pedagogy of medical blogs, and the consultative register more common to pathographies and other forms of cybermedicine controlled largely by non-practitioners. Healthcare promotional writing is often relegated to these types of government or government-sponsored websites and is sometimes authored by designated public relations writers who may or may not have any direct field experience in healthcare. Like writing for social media and other types of cybermedicine, the writing is also designed to be asynchronous, meaning it is authored and published not as a single, standalone website or webpage, but as a series of incremental, intermittent writings that do not necessarily need to flow in immediate or linear succession. Given that a social media narrative, however brief, can be written at one time and then read and responded to at another time, allows authors publishing on the web using these means to compose narratives that are not confined to conventional writer–reader exchanges. Not unlike how web-based learning and online training are referred to as a asynchronous learning, so too does **asynchronous writing** generally describe any form of computer-mediated composition and communication. As social media in particular has evolved from being a pastime to a key resource available to practitioners to engage in everyday health promotion and reach wide audiences through their writings, the sometimes-controversial practice has come to take on a name of its own—Health 2.0.



Government agencies are not the only health organizations and administrators who have taken to the internet as their principal health promotion platform. Organizations representing clinician-academic partnerships, such as EatRight.org, are part of a new movement by nongovernmental organizations (NGOs) to take responsible control of the electronic narrative on all things related to healthcare while also providing resources and research to the public. Here, we see a landing page link to a piece discussing the nexus between lead levels in the body and nutrition. Written in a healthcare wiki style but with no presumptions made with respect to knowledge of specific technical terms, the information is presented with concision and using a consultative register.

As the latest iteration of cybermedicine, [Health 2.0](#) describes the second version of cybermedicine commensurate with advances in internet computing technologies; specifically, it describes a version of cybermedicine in which asynchronous writing for social media platforms by clinicians and other healthcare practitioners and scholars is becoming increasingly recognized and legitimized among peers. As a confluence of healthcare theory and practice and the cultural enormity of Web 2.0—generally epitomized by the semantic web and influence of social media—Health 2.0 is a collection of online resources that can be used for the purposes of health promotion. By extension, Health 2.0 writing denotes any type of electronic writing that makes use of the internet's current architecture to advance health-related interests and education. While it could be argued that we are currently entering the next generation of the internet, or Web 3.0, which will be defined later, by personalizing and ensuring an even greater focus on learning and instruction (Ifenthaler, 2011), the existing and still expanding array of health promotion writing is very much grounded in Web 2.0 applications.

While the medical blog has come of age and is now understood as a progressive and, when used appropriately, effective resource for practitioners as both the writers and readers of online content, social media writing in the context of healthcare communication is still in a comparative age of adolescence. One of the main criticisms of social media writing in healthcare is the fact that, unlike blogs and wikis that require substantive investment in terms of time and effort, social media platforms generally lack these types of quality controls and vetting with respect to content. With the internet often being a source of misinformation as much as credible data, the additional concern is that using a “social” outlet for the dissemination of healthcare information can exacerbate this issue, as the line between personal and professional communication will ultimately become blurred and erode the integrity of healthcare writing. The most recently published assessment of the relationship between cybermedicine and clinical accuracy (Giustini, 2006) actually suggests that only six per cent of health information posted on the internet—

including to social media sites—is factually correct, on a good day. Given such stark figures, the professional climate surrounding the perceived role and value of social media as a health promotion and publishing resource is changing. Given also the ever-changing and expanding landscape of social media itself, selecting which outlets are suitable for healthcare or health promotion writing is therefore a matter of professional strategy. Practitioners, before delving into social media as either a writer or a reader in the context of healthcare, should first seek to identify what sites or platforms are most useful—and credible—with respect to healthcare professionals as promotional or educational tools.

HEALTHCARE AND MICROBLOGGING

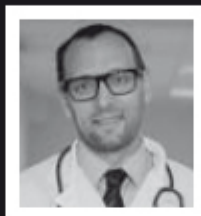
As social media and health promotion sites enter a more evidence-based partnership according to recent studies (Cheston, et al., 2013; Hollinderbäumer, et al., 2013), and with social media's role in shaping healthcare education and training becoming increasingly legitimized, it should be noted that not all social media sites are suited to this type of comparatively congenial prose. In fact, social media sites that approximate the format of a medical blog in terms of formality and vertical communication—where the author maintains control over what is posted and where readers come to the author rather than a common site—tend to be the most favoured by practitioners in terms of effectiveness and reputation.

Twitter, as what is known as a microblogging site, is arguably the most used social media platform for the purposes of writing about health for healthcare professionals. Twitter, created and launched in 2006, combines both social networking—and by extension professional networking—features with the top-down narrative format of a blog. Unlike a blog, however, where content is typically not restricted in terms of length, Twitter features a built-in editing component that limits all pieces of writing to 140 characters. Writing with concision on Twitter is therefore a matter of necessity and emulates the type of fixed text box writing and self-editing seen in many hospital flowcharts ([chapter 1](#)). Twitter text submissions as a social media extension of this same writing strategy engenders its own distinct form of prose that favours short, declarative statements that reflect exposition more than any other rhetorical mode. This same process of concision is also the reason Twitter is known as a microblog, in that each piece of writing, known as a tweet, amounts to a miniaturized blog narrative. Because concision prompts a standardized form of exposition among Twitter users, professionals generally—including medical practitioners—favour Twitter as a communications resource. For the same reason, it is optimal for health promotion. Given that health promotion online is fundamentally about education, awareness, and public engagement, using Twitter for this purpose has proven to be an effective medium to disseminate and promote health-related information quickly and succinctly for many practitioners—and, unlike many blogs, at no cost.

Just as unique visitors and page clicks serve as proxies for the relevance of a piece of writing in a medical blog, the reach of microblogs posted by Twitter accounts can also be numerically quantified. However, because metrics with respect to activity surrounding a particular Twitter account are not accessible to individual registrants, the number of other unique users, or “followers” who link their profiles to someone else's, serves as the best representative of an identifiable readership. Unlike in the case of medical blogging, no SEO keywords or other lexical strategies can be used to rank a page or direct readers to content following a general internet search. Instead, practitioners taking to Twitter as a means of advocating for a specific care regimen, disseminating research, initiating dialogue or debate on healthcare topics, or engaging in any number of other forms of writing and communication that qualify as health promotion need to make wording choices directly within their profiles in order to attract readers. Just as the medical blog links online health writing with scholarly journal writing in terms of their sharing

the use of keywords as a rhetorical strategy, so too is there a nexus between microblog and another hallmark of journal writing—the abstract.

Abstract writing is covered in [chapter 8](#), but it should be noted that while journal submissions and chapters submitted for publication in medical anthologies typically require abstracts that effectively summarize the thesis, scope, and research questions of a scholarly or scientific essay or study, Twitter—or any social media profile used by practitioners—similarly requires a summary of the author’s credentials, current posting, position, or title. The Twitter abstract, for lack of a better word, should contain a basic overview of what readers can find within the profile, whether by linking themselves to it as followers or by simply returning to view updated content regularly. Original articles containing peer-reviewed research appearing in edited books and journals have abstracts that range in length from 150 to 250 words on average. Social media profiles also typically contain restrictions on length and require writing with concision; this is especially the case with Twitter where, like the editorial limit of 140 characters placed on each tweet, an analogous 140-character limit is placed on the abstract summarizing the profile holder as author, including a summary of his writing.



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Cancer Centers of America – Tweeting on Palliative & Supportive Care
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- Personal screen name (denoted with @) should generally correspond with the user name or reflect the branding or philosophy of the profile.
- Biographical information should reflect current appointment, research portfolio, specific training, and/or scope and content of tweets.
- Email address or URL for a website or blog refers readers to external sources consisting of similar written content.

Abstracts on Twitter function as biographies and statements of intent about the content to be written, as well as a summary of existing material. Whether the profile represents an individual or a healthcare institution, the user name, screen name, and 140 characters of content in the abstract should all converge in terms of style, content, and consistency in much the same way that SEO keywords appear in the web pages tagged with those same words. The interplay between text and image should also make it clear to readers that the profile is a platform for health communication and promotion. Accurately and effectively branding the profile as medical in nature is therefore key to attracting followers and even occasional readers, as well as making meaningful connections among colleagues with similar interests, or in establishing networking connections between healthcare institutions.



XYZ Hospital ✓

@xyzhealthcentre

Expert health tips, medical news & current events from our health sciences centre, research park, foundation, & sports injury clinic. Core areas: Heart, Trauma, OB-GYN, Neck & Spine, Sports Medicine & ENT

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- Institutional name, screen name, and user name should all match as closely as possible.
- Purpose of the profile and what it offers readers and/or followers should be clearly spelled out. In this case, “health tips” is the branding strategy used to promote and inform on topics related to medicine and holistic wellness.
- Location(s) and URL for official website should be clearly listed.

Beyond the effective use of exposition in Twitter abstracts to attract readers, followers, and otherwise establish meaningful connections and affiliations with other practitioners and healthcare stakeholders—including patients—Twitter also enables a number of other rhetorical strategies. These strategies define the user experience of Twitter beyond the design of the profile page and can help serve the writer’s interests once the microblogging process is actually under way. There are a number of features built in to Twitter, for instance, such as the use of hashtags and hyperlinks that allow the 140-character limit—drawing on the principles of shorthand and concision discussed in [chapter 1](#)—to be maximized for the purposes of health promotion. Even with the editorial limits placed on the length of each prose submission, Twitter is designed to not only keep content manageable, but also for written submissions to serve as links to other resources, both internal and external to the site. Bearing this in mind, some of the key advances and most common applications of Twitter as a healthcare promotional forum include the following:

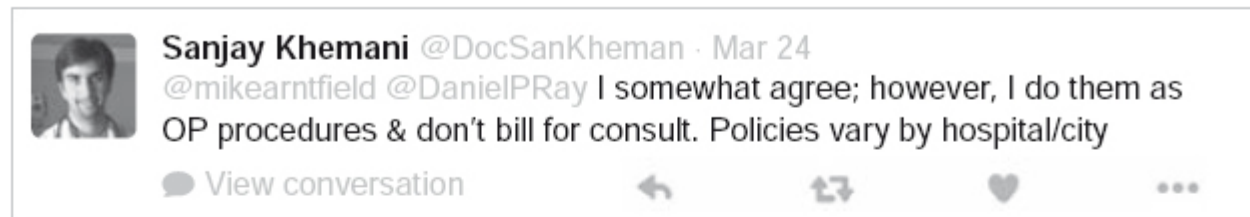
Professional dialogue and collegial debate:

Social media, when properly utilized and when professional decorum is observed, offers an excellent opportunity for practitioners to engage in meaningful and constructive discussion about matters of collective professional, clinical, or public interest. The public nature of these dialogues should be kept in mind when responding to pointed queries or hypotheses. On Twitter in particular, the purpose of enabling public disclosure with respect to this dialogue is ultimately to educate, inform, or prompt others to join. For this reason, in terms of healthcare promotion, these exchanges are typically made on the public timeline or “feed” rather than as discreet inbox messages that are not viewable by outsiders, and which don’t allow for more than two participants.

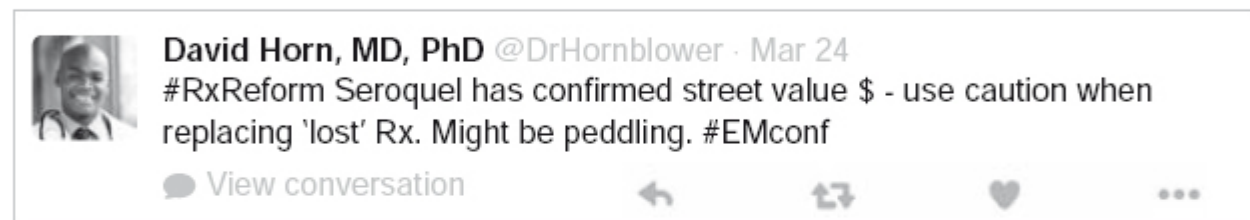
Healthcare news, alerts, and advisories:

Social media, due to its asynchronous yet still instantaneous design and ability to vertically disseminate information very quickly is a great tool for sharing and recirculating healthcare news stories, alerts, or advisories of wide interest. Given that most social media sites include mobile versions, messages of this nature can be composed in the healthcare delivery environment or

discreetly while at medical lectures, and then delivered en masse to a wide readership. On Twitter, as the preferred social media tool for practitioners, topics offering this type of collective interest and timeliness can in turn be flagged as “trending topics” through the use of a hashtag (#) preceding the topic word or abbreviation. Flagging, or tagging, a word or set of words in this fashion allows users to contribute to an ongoing dialogue and link their narratives to other posts with similar content.



- Conversations or debates between multiple contributors should include links to the other related profiles, as well as single questions, answers, rejoinders, or statements made within the 140-character limit.
- Transcripts of full conversations are collapsed into a separate link for future reference.



- Topics of conversation threads or tweets on topics of common interest are denoted by the use of hashtags (#) to hyperlink tweets to the topic in question. As in this case, they make effective use of the character limit and can be used to bookend important or timely announcements.

Medical education and conference information:

Given that social media is really just one version of healthcare promotional writing, it stands to reason that social media content should complement other forms of promotion occurring offline. Social media applications like Twitter are the public face of medical education and awareness initiatives that are relegated to more formal environments, such as academic or clinical conferences and symposia, up to and including Chief's Grand Rounds in teaching hospitals. During the course of microblogging, details about one's attendance at such an event, the location and topic of the event, keynote speakers, and brief information on plenary sessions can normally be included in the 140-character limit. Any external links to relevant websites of interests, or a link to a new or existing hashtagged topic encompassing either the event itself or the topics covered at the event should also be included.



Jenna Cooper @JennaCooper1978 · Mar 24

Currently watching the keynote speaker re: diagnostic errors in ER medicine. #sidm2013

Expand



- Often, the shorter the tweet the more effective it can be in piquing interest in healthcare-specific events, such as conferences, conventions, press and/or funding announcements, and symposia. The use of a web URL or hashtag to take readers to another forum for further information is an effective way to punctuate and contextualize these brief announcements.

Twitter is only one of several options in a seemingly ever-expanding menu of social media platforms offering increasing specificity and customization with respect to targeted readers. A number of these platforms are owned by single media conglomerates and allow for remarkable sharing of contacts, images, and other data; yet, in spite of an increasingly crowded market, it would seem that just a handful of platforms have been legitimized as suitable for professional and clinical information exchange and promotion—at least in healthcare. Twitter as one such platform has achieved a preferred status in the medical community for the purposes of health promotion in part because of how it approximates the medical blog, arguably the defining narrative of cybermedicine.

Outside of social media as conventionally understood, there are other inherently “social” applications of cybermedicine that also function as outlets for health promotion and information exchange, and that necessitate a certain command of exposition and writing with concision. While current iterations of social media offer healthcare practitioners yet another dimension of cybermedicine to use in their promotional writing and while social media can certainly elevate the public profile of clinicians and educators, certain groups within healthcare and more specifically health promotion prefer to communicate in their own private spaces. Marked by a degree of exclusivity and restricted access in comparison to the universal access afforded by both blogs and social media, these narrative spaces are similarly collegial and about establishing connections and fostering dialogue, but they do so out of the public eye. As a result, there are some special considerations when writing content for such groups; the fact that the content is not subject to public view does not diminish the expectations with respect to accuracy and decorum of content. In fact, just the opposite: these spaces tend to have some of the highest expectations with respect to both procedural and promotion exposition in healthcare writing.

WRITING FOR DISCUSSION LISTS AND MAILING GROUPS

While not usually considered an adjunct of social media, the expanded use of electronic mailing groups, discussion lists, and what are often called listservs actually epitomizes the networking infrastructure of Web 2.0, as well as the general philosophies of cybermedicine with respect to access and engagement. The term “listserv” is actually what is known as a proprietary eponym, or a genericized trademark whereby a name brand becomes a substitute noun used to describe similar items (Kleenex as a substitute for tissue, Thermos as a substitute for flask, etc.). Dating to early Web 1.0 in the late 1980s, LISTSERV as a proprietary, trademarked term was the first cross-platform electronic mailing group, and has since been used to describe similar services today. Healthcare, and by extension cybermedicine, is one of countless professions taking advantage of the targeted, restricted, and yet also very interactive nature of such mailing groups. In terms of health promotion, these groups also offer specific opportunities for practitioners to write for publication to a specific audience with specific expectations, and an online culture with its own writing etiquette and decorum.

Healthcare mailing groups and discussion lists fit a unique niche in terms of professional writing—one part clinical, one part narrative, one part interpersonal. Many of these groups have memberships that are populated solely by invitation or referral, effectively limiting the readership to other practitioners with similar areas of practice or expertise. This is done largely to limit the scope of discussions and postings as a matter of necessity, and to avoid message threads from becoming too discursive or digressive. Many of these groups also have specific terms of use and codes of ethics in order to maintain membership and good standing. Many are also affiliated with universities, healthcare institutions, or research facilities, or some combination of all three, and with members representing both private and public health bodies, as well as both medical practice and education. Unlike conventional social media platforms where authors are left to their own devices and good judgement in terms of what and what not to post, the confidentiality agreements required to be honoured by members of mailing groups and those contributing to discussion groups ultimately limits the breadth of the promotional or educational content being composed. At the same time, these confidentiality agreements also enable authors to write more candidly than they might in other electronic forums. Just as in microblogging, this candour frequently involves responding to other writers or content posters by name, or offering rejoinders to existing threads or conversations that are carried on in view of other users.

Given that the customary composition format for communication within discussion lists is email, the style and decorum outlined for electronic correspondence in [chapter 2](#) should prevail when drafting original contributions or responses within a mailing group. Despite the fact that confidentiality rules apply to most or all correspondences, authors should still be mindful of the fact that, like all electronic submissions, the continuity of documents can never be ensured. The fact that postings can and in many cases will—in spite of the terms of use set out by a group's administrators—travel beyond the sanctum of those within the group should therefore deter authors from posting content that they otherwise would not post to a blog or other social media sites for a public audience. Many of these groups, because they exist for promotional and educational purposes, will also allow the release of posts or information contained for instructional purposes. This means that any studies, published work, or other data being referenced in a post to the group should defer to the scholarly writing format with respect to citations outlined later in [chapter 8](#).

By blending the lessons drawn from [chapters 2](#) and [7](#) with respect to style and format, and building on the stylistic and rhetorical guidelines outlined in this chapter, healthcare writers gravitating toward health promotion writing can effectively capitalize on the exclusive networking and information sharing afforded by cybermedical discussion lists and mailing groups as both contributors and administrators. By recognizing social media as a now legitimized and professionally recognized mechanism for health promotion, cybermedical writers should also understand social media as being a philosophy of health promotion as much as an arena for networking. Social media is a philosophy that pervades much of healthcare education and training, as well as a narrative forum and resource that draws young people toward careers in medicine.

CHAPTER SUMMARY

By this point, you should be able to:

- Differentiate healthcare practice and healthcare promotion, and also describe how the two might relate under the umbrella of public health.
- Understand how public health documents represent examples of grey literature and be able to adequately define (with examples) both “public health” and “grey literature” as a corollary of your being able to lead a discussion on this topic.

- Discuss the relationship between medical blogging and healthcare microblogging, and whether there might be advantages as a practitioner in engaging in both, or whether some specialties and healthcare occupations perhaps favour one over the other.
- Define Health 2.0 and explain how current practices with respect to cybermedicine in the context of social media might serve as additional examples of technological determinism in healthcare writing.

Some self-check or class discussion exercises you might want to try include the following:

- Select two healthcare-oriented profiles on Twitter, one institutional profile and one personal/professional profile, and examine the biographical information listed in the abstracts. How does the integration of text and image serve to cultivate the various forms of rhetoric?
- Have a look at these same profiles and ask yourself which of the three common applications of Twitter for public health purposes seem to be the most frequent uses of the profile: (i) initiating or inspiring professional dialogue and collegial debate; (ii) disseminating healthcare news, alerts, and advisories; (iii) posting updates relating to medical education and conference information.
- Have a look at some public health websites operated or administrated by government, NGOs, or specific healthcare institutions and consider how the writing either converges with or diverges from other types of cybermedical prose. Who, in your opinion, is the intended reader for these sites?
- Create a list of broad healthcare topics that you are interested in, either in terms of practice, promotion, or education, and ask yourself if a targeted mailing list to further discussion in this area is warranted. There probably already is one somewhere, but if you were to create your own group from the ground up and be the administrator, who might be the first five people you would reach out to or otherwise encourage to join? What might your group guidelines and terms of use look like? What might be some topics you would spearhead for discussion?

PART III

Fundamentals of Successful Healthcare Writing

This chapter marks a shift away from what has been our primary focus up to now—namely, the modes of and strategies for contemporary healthcare writing—and towards a broader concern with the things upon which all effective writing depends, regardless of its purpose and context. As the title anticipates, the aim of this chapter is to introduce and discuss some fundamental considerations of grammar, punctuation, and style for healthcare writers. To that end, it is useful here at the outset to start by defining and distinguishing between the key terms at stake since they necessarily underpin all of our discussion going forward, yet they are terms often confused or conflated in general usage.

Grammar refers to the study of how and why language works; its concern is with the rules and conventions that help us understand the means by which words can be correctly combined together into larger meaningful units. **Style** refers to the way a writer chooses to approach a document, and it accounts for such things as tone, diction (word choice), syntax (word arrangement), and sentence type or length. Unlike grammar, style will tend to be a function of choices made in response to contextual considerations, such as perceived audience and/or awareness of a given document's purpose. Punctuation is the practice of indicating and clarifying the intended relationship of grammatical units to each other by means of using marks (such as periods, commas, semicolons). **Punctuation** marks are employed both to support the grammar of a sentence and (where there is range of possible punctuation marks that are all equally grammatical) as an aspect of style. Taken together, the considerations of grammar, style, and punctuation define the study of rhetoric, a term, as outlined back in [chapter 1](#), that refers to the art of writing or speaking effectively, engagingly, and convincingly.

To write well requires time and effort; like any useful skill, writing demands persistence and a willingness to engage in the necessary and frequently tedious processes of drafting and revision. It may not seem necessary to state, but the only way you can improve as a writer is to write (and rewrite) as often as you can. Thus, the old adage that “practice makes perfect” seems to hold true. As professional athletes and their coaches are so prone to remind us in various ways, however, it is more than simply repeating a skill over and over that breeds success. Rather, real improvement can occur only through practising effectively and correctly—that is, practising with a view to the importance and proper execution of particular fundamental skills. Of course, when the legendary National Football League (NFL) coach Vince Lombardi referred to practice as the key to improvement and success in football, the fundamentals he wanted his players to bear in mind were things like blocking, tackling, route-running, and quarterback play. So then, what are the analogous fundamentals writers need to keep in sight whenever they want to practise most effectively?

For any writer, practising well necessarily entails writing with an understanding of how and why the words you write work together to convey ideas clearly and correctly as well as of how to punctuate within and between groups of words in ways that reflect the relationships you want those groups of words to have. Having some mastery of the main rules and conventions that govern grammar and punctuation and knowing how those rules and conventions apply in any given instance of writing (healthcare-related or otherwise) goes a long way toward ensuring that

what you write is both clear and correct. And despite what seems unfortunately an all too common perception among students, grammar and punctuation are indeed things writers can master.

Note that mastery does not entail knowledge that is comprehensive, rather knowledge that is functional; there is a difference. It is not important for a nursing student to learn to distinguish between absolute and appositive phrases, for example, or to recognize and recite all of the various possible combinations of verb tense, aspect, and mood. Instead, what is important for that student is to be able to articulate effectively his key ideas within a given real-world document—a narrative report in a transfer of care document, an email or memo to colleagues, a research paper, a critical analysis essay—and then to link those ideas together in useful, logical ways that contribute importantly to the document's coherence and the reader's ease of understanding. Returning to our football analogy, the desired end result of practising well (despite the old “practice makes perfect” expression) is not really to be perfect. Instead, it is simply to become more confident that you have close at hand the basic knowledge and skills required to do some task competently and correctly going forward, every time that task arises, whether it be converting a third down pass or writing a literature review for an upper-year health sciences course. In the end, “practice makes permanent” actually seems a more apt statement, certainly as it applies to writing.

Confident, competent writers know that, despite how things like purpose, audience, format, and tone will vary from document to document, good writing in every healthcare context is going to be in main the product of correctly applying one's foundational understanding of grammar, punctuation, and stylistic options. And in order to take the first logical steps toward acquiring such understanding, it is necessary to begin at the beginning, as obvious as that notion might sound. The smallest, most basic grammatical units are individual words. Thus, it is with an overview of how words work on their own and in conjunction with each other to give shape to our ideas that we start.

WORD CLASSES

There are just eight distinct, identifiable word classes (or parts of speech) in English: nouns, pronouns, adjectives, adverbs, verbs, prepositions, conjunctions, and interjections.

Nouns

Conceptually, **nouns** are people, places, or things (e.g., Professor Jones, Toronto, x-rays). Note that with respect to this last category, nouns can be referred to as either concrete (when they name physical things like x-rays) or abstract (when they name concepts like liberty or insight or sickness).

Grammatically, nouns are subjects and/or objects. A noun that is a subject will name the who or what we are talking about in any sentence. At least conceptually, all sentences will begin with a noun because we are necessarily always trying to say something about or in reference to a person, place, or thing. In the sentence “University Hospital is an excellent facility,” *University Hospital* is the subject as it is the thing about which the writer is making a statement (that it “is an excellent facility”). To be more precise, the single-word subject in this example is the noun *Hospital*, so we call that the **simple subject**: the boiled-down who or what our sentence is about, stripped of any words that modify or describe it. By contrast, we call *University Hospital* the **complete subject**: a noun phrase consisting of the simple subject plus any modifying words.

Objects too can be understood in the simplest terms as who or what. Unlike subjects, however, objects are not nouns that name who or what the sentence is about; rather, they are people,

places, or things named in the course of describing or saying something about the subject. Consider the following sentence:

Dr. Jorgensen conducted her neurobiology lectures in the new health sciences building.

The subject here is a noun naming a person, *Dr. Jorgensen* (as it is about her that we are making a statement). However, there are two other nouns in the sentence additional to the subject, both naming things. These are objects. The first (*lectures*) is the **direct object** of the **verb** *conducted* because it names the things that are directly acted upon by the action of the verb. The second (*building*) is the object of the **preposition** *in* and works with that preposition to make a phrase (*in the new health sciences building*) that provides descriptive detail to our statement about Dr. Jorgensen.

To these two types of objects we can add a third: indirect. While the direct object names the person/place/thing directly affected or produced by the action of the verb—the things being *conducted* by Dr. Jorgensen in our example—an **indirect object** names someone or something involved in or affected by the action of the verb only secondarily.

Dr. Jorgensen frequently offered tutoring to struggling pre-med students.
[SUB.] [DIR. OB.] [IND. OB.]

In this example, the indirect object is *students* because that noun names the people who are affected by and benefit from the action of the verb (*offered*) but who are not directly acted upon by it. They are not who/what is being offered; *tutoring* is, and thus it is the direct object.

Importantly, note that indirect objects will always either follow the prepositions *to* or *for* (as in our example: *to struggling pre-med students*) or be understood to follow them (as in the case of our example above being rewritten this way: “Dr. Jorgensen frequently offered struggling pre-med students tutoring”). For this reason, it is sometimes helpful to identify indirect objects by asking yourself whether there is someone or something named *to* or *for* whom the subject is carrying out an action. Put another way, ask yourself whether or not someone or something is the receiver of the direct object. In our example, the struggling students receive the tutoring; it is *to* or *for* those students that the tutoring is offered by Dr. Jorgensen.

But if indirect objects always follow (or are understood to follow) prepositions, then why aren't they just objects of prepositions? The easy answer is that they are ... kind of. Like objects of prepositions, indirect objects (when they actually do follow *to* or *for*) combine with the prepositions that precede them to create phrases that modify or describe; *to the struggling pre-med students* provides useful contextual detail to the more vague statement that *Dr. Jorgensen frequently offers tutoring*. What makes an object of a preposition an indirect object is whether we can think of it as receiving the direct object (and thus as being indirectly or secondarily affected by the action the subject is described as undertaking).

Dr. Jorgensen rarely gave high marks to students who did not attend her class regularly.
[SUB.] [DIR. OB.] [IND. OB.]

Some of those students drafted a letter for the Dean expressing concerns about unfair treatment.
[SUB.] [DIR. OB.] [IND. OB.]

In the first example here, the noun *students* is an indirect object because it names the people who receive (or rather, don't receive, in this particular instance) *high marks*, the direct object of *gave*. They are obviously affected by Dr. Jorgensen's action of (rarely) giving, but they aren't directly acted on in the way that the *high marks* are, since those are what's being given. Similarly, in the second example, the noun *Dean* is an indirect object, naming as it does the person who will receive the *letter* (direct object) that is produced through the action named by the verb *drafted*. However, consider this example:

My anatomy lab partner takes the Wellington 13A bus to campus every day.
[SUB.] [DIR. OB.][OB. OF PREP.]

Here, the noun *campus* is the object of a preposition (*to*); it is not an indirect object because it doesn't name something that can be understood to receive the direct object (*bus*) of the verb *takes*. The phrase *to campus every day* functions (as all other such prepositional phrases do) to provide modifying, contextualizing detail. It tells us *to where*, while a prepositional phrase containing an indirect object would tell us *to whom*.

Thus, it might be useful to think about indirect objects not only as receiving direct objects, but also as (usually) being aware that they are. The grammarian Max Morenberg talks usefully about indirect objects almost always having to be both **receivers** and **perceivers** (2010), and that is true. Rarely will we encounter a scenario in which the indirect object is a noun naming something other than a sentient person/animal, though here are a couple of examples:

Joan's roommate gave her spare time to a cancer charity.
[SUB.] [DIR. OB.] [IND. OB.]

The empty waiting room lent an unsettling peacefulness to the clinic.
[SUB.] [DIR. OB.] [IND. OB.]

In both of these sentences, we have indirect objects that aren't readily thought of as perceivers. While you could perhaps think of the noun *charity* as referring to the people who run the organization rather than to the organization itself, it seems a bit more difficult to personify or animate *clinic* along similar lines, though you might. In any case, neither *charity* nor *clinic* seems to name a sentient thing in any obvious way, yet both are indirect objects because they nonetheless identify who is receiving the direct object in each sentence. The prepositional phrases of which these nouns are part tell us *to whom* (or *what*) rather than *to where*.

One more thing: when in doubt as to whether a noun following *to* or *for* is the object of a preposition or an indirect object, you can always try rewriting your sentence by putting that noun after the verb, eliminating the prepositional phrase (per the form of our earlier example "Dr. Jorgensen frequently offered struggling pre-med students tutoring"). If you can do that and have the sentence still make sense, then the noun in question is an indirect object. For example:

The empty waiting room lent an unsettling peacefulness to the clinic.
[SUB.] VB. [DIR. OB.] [IND. OB.]

The empty waiting room lent the clinic an unsettling peacefulness.
[SUB.] VB. [IND. OB.] [DIR. OB.]

By contrast, go back to the example of “My anatomy lab partner takes the Wellington 13A bus to campus every day.” It cannot sensibly be rewritten as “My anatomy lab partner takes campus the Wellington 13A bus,” and the fact that it can’t reaffirms what we’ve already noted about *campus* not being an indirect object.

Pronouns

These words stand in place of and refer back to nouns. *Pro* is the Latin preposition *for*, so the name of this word class can help remind us of its function—to stand in *for* nouns. The nouns for which **pronouns** stand in place and to which they refer back are called **antecedents**. In effective writing, the relationship between any pronoun and its **antecedent** needs always to be clear and unambiguous.

We can usefully divide pronouns into several subcategories, which include the following:

Personal pronouns (such as *I, you, she, they, it*) used to replace/refer to nouns naming specific people or things.

Our pediatrician is often difficult to get in to see because she carries such a high patient load.

Every day brings with it a whole new set of challenges for a first-year nursing student.

Reflexive pronouns (such as *himself, yourself, myself, itself*) employed in constructions wherein the subject and object are the same person or thing.

Dr. Jorgensen surprised herself with the ferocity of her response.

Demonstrative pronouns (such as *this/that, these/those*) point or gesture to a previously named (or clearly understood) thing. The demonstrative can either stand on its own in place of the noun to which it points (its antecedent), or it can precede that noun as a modifier.

Those must always be sterilized prior to doing a biopsy.

Those curettes must always be sterilized prior to doing a biopsy.

The first example depends heavily on context to be clear and effective. The reader needs to have some understanding of just what it is *Those* refers to for the meaning of the statement to be conveyed accurately. Including appropriate nouns after demonstratives is almost always a good choice with respect to writing with clarity and precision.

Relative pronouns (such as *that, which, who*) connect their antecedents to another **clause**—a group of words containing a subject and a verb—that describes or refers to the antecedent. We will have more to say about clauses shortly. For now, note that relative pronouns function to introduce subordinate clauses; that is, they introduce conceptually dependent clauses that cannot stand on their own as sentences.

Jorge’s wife gave a touching card of thanks to the palliative care nurses who made her husband’s last days so comfortable.

There goes the Wellington 13A bus that my lab partner takes to school.

Indefinite pronouns (such as *some, many, everyone, anyone, each*) present something of an exception to the rule that pronouns need always to have a clear antecedent. These are pronouns that often don’t refer back to anyone or anything specifically, and they are thus used in broad,

gestural ways to make general statements. As such, they should be employed with particular care, at the risk of lending unwanted imprecision to your writing.

A Common Point of Confusion: Who vs. Whom

Many writers have difficulty sorting out when to employ the different case forms of the relative pronoun *who*. Sometimes the easiest way to figure out whether it's *who* or *whom* in any instance is to try rewriting the sentence in question using a personal pronoun (such as *he/him*).

The radiologist who looked at my films was a recent Western University graduate.

The radiologist whom my mother met yesterday had not seen her x-rays.

In the first example, *who* is the subject in the subordinate clause "who looked at my films." Were you to rewrite that clause with a personal pronoun, it would be "he looked at my films," not "him looked at my films." And we know *he* is the subjective form; thus, *who* is the correct pronoun. Likewise, in the second example, *whom* is the direct object of the verb *met*; you can prove it by trying to rewrite the particular clause in question as "my mother met ____ yesterday." It would be "my mother met him yesterday," not "my mother met he yesterday." Thus, *whom* (the objective form) is indeed correct.

The same trick goes for questions beginning with *who/whom*: try answering the question using a personal pronoun, then match the case of *who/whom* to the case of that pronoun.

Who are you bringing to John's graduation party?

Answer: "I am bringing her." Thus, the objective case is needed here, so the question should actually be "*Whom* are you bringing to the party?"—despite how oddly formal it might sound.

Anyone taking this medication should be made aware of its side-effects.

Like demonstratives, indefinite pronouns can stand on their own in place of nouns, or for the sake of greater clarity they can accompany and precede as modifiers the nouns to which they refer.

I need a copy of *Elements of Style*; does the bookstore have many left?

Does the bookstore have many copies left?

Case refers to the form a pronoun takes according to its grammatical function within a sentence: whether it is acting as subject (nominative or subjective case), object (objective case), or to indicate ownership (possessive case). Pronouns generally have different forms according to their case, though they will not necessarily change form for all three cases. Consider the following examples:

SUBJECTIVE CASE FORM

I
you
she
it
who

OBJECTIVE CASE FORM

me
you
her
It
whom

POSSESSIVE CASE FORM

mine, my
yours, your
hers, her
its
whose

Like demonstrative or indefinite pronouns, many pronouns in the possessive case can be used either on their own to stand in place of an antecedent or as modifiers alongside the nouns to which they refer.

This is my cup of coffee. That one getting cold on the counter is yours.

Adjectives

These words modify nouns and pronouns, which is to say that they provide descriptive information that makes nouns and pronouns a little more specific or striking. Again, knowing something about the Latin roots of the word can be helpful; *ad* is the preposition *to*, a fact which can remind us how modifiers work to provide additional information to other words. The details provided by **adjectives** can help us answer the questions *which (one)?* or *what kind?* with respect to the people, places, or things being described.

Dr. Jorgensen could give lucid and engaging lectures on almost any aspect of neurobiology.

To learn to write effectively, students must first be familiar with the eight parts of speech.

As the second example here indicates, **articles**—which can be either definite (*the*) or indefinite (*a/an*)—fall under the category of adjectives because they necessarily always precede nouns (e.g., the parts, an egg, a book), even though they perhaps don't answer *which one/what kind?* quite as clearly or usefully as other adjectives do.

Casting back to our discussion of pronouns, note that when demonstrative, indefinite, or possessive pronouns are used to precede and modify the nouns to which they refer (e.g., those cures, many copies, my cup), those pronouns are being made to function as adjectives.

Adverbs

These words are also modifiers, but they modify verbs, adjectives, other adverbs—anything other than nouns or pronouns. **Adverbs** answer a variety of questions with regards to the words they modify: How? How often? When? Why? To what extent or degree?

Dr. Jorgensen too frequently wears that bright green blazer to class.

In this sentence, *frequently* is an adverb modifying the verb *wears*, *too* is an adverb modifying *frequently*, and *bright* is an adverb modifying the adjective *green*.

Note that adverbs are usually flexible in terms of where we can locate them in a given sentence whereas adjectives are not. Adjectives need to stay close to the nouns or pronouns they describe. With respect to the example above, the sentence still makes sense when we rewrite it with the adverbs *too frequently* in different spots: “Too frequently, Dr. Jorgensen wears that bright green blazer to class,” or “Dr. Jorgensen wears that bright green blazer to class too frequently.” It doesn't make sense any more, however, if we try to move the adjective in the same way: “Green, Dr. Jorgensen too frequently wears that blazer to class,” or “Dr. Jorgensen too frequently wears that blazer to class green,” or “Dr. Jorgensen too frequently wears that blazer to green class.”

One subspecies of adverb that is particularly important to clear, persuasive writing is the **conjunctive adverb**. This term refers to some of the important and necessary logical markers of cause/effect, comparison/contrast, and sequential order that we use all the time, especially in academic writing, to map the particular relationships we want to establish between ideas. Among the most common conjunctive adverbs are *also*, *besides*, *consequently*, *finally*, *first*, *furthermore*, *however*, *indeed*, *likewise*, *moreover*, *nonetheless/nevertheless*, *notwithstanding*, *rather*, *then*, *therefore*, and *thus*. These words all help us give readers some indication of how we intend our writing to be

read or understood: “what I’m now going to say needs to be understood as a consequence of what I just noted”; “what I’m telling you here is the case in spite of something I’ve just argued”; “this idea will give you a further, more telling illustration of the point I’ve just made.” For this reason, conjunctive adverbs are a common, subtle way for writers to provide **metacommentary**—moments in which we signal to the reader just how to interpret our ideas in relation to each other.

Conjunctive adverbs are at once **conjunctions** (connecting words) in that they relate one sentence element (a main clause) to another and adverbs in that they can be moved to several different places within a given sentence without altering the sense or meaning of that sentence. Consider this example:

Monica took several writing and speech courses; therefore, she is now a more confident communicator with both patients and colleagues.

Here, *therefore* defines a particular logical relationship between the second clause and the first. And the sentence can be rewritten to mean the same thing despite *therefore* being moved to different places in the second clause (a fact which denotes the adverbial nature of *therefore*): “Monica took several writing and speech courses; she is now, therefore, a more confident communicator ...,” or “Monica took several writing and speech courses; she is now a more confident communicator with both patients and colleagues, therefore.”

One last important thing to note about conjunctive adverbs (again to look ahead a bit to our discussion of clauses and phrases below as well as to our discussion of avoiding sentence boundary errors) is that they link main clauses—groups of words that can stand on their own as sentences. As we will see, to avoid a serious and all too common punctuation error, main clauses joined with a conjunctive adverb must be punctuated in relation to each other as they would be if the adverb weren’t there. Thus, in such situations, conjunctive adverbs are invariably preceded by either a period or a semicolon.

Verbs

Verbs are usually action words (like *jump* or *learn*), and they introduce the portion of a clause that tells us something about the subject (the portion known as the **predicate**). Note that some verbs—such as *feel*, *be*, *seem*, and *appear*—describe states of being or experience, rather than actions. These verbs are called linking verbs. Verbs in sentences are conjugated, which means that they change their form to indicate the time of the action (the **tense**), as well as whether that action has been completed or is ongoing (the **aspect**). The following chart illustrates various tense-aspect combinations for the verb *to learn*, conjugated as if that verb’s subject in each instance were the pronoun *you*:

TENSE	ASPECT			
	Simple	Perfect	Progressive	Perfect Progressive
Present	learn	have learned	are learning	have been learning
Past	learned	had learned	were learning	had been learning
Future	will learn	will have learned	will be learning	will have been learning

Note how in every form other than simple present and past, the verb being conjugated requires help from other verbs to indicate the appropriate tense and aspect. Those helpers (i.e., *will* and the forms of *to have* and/or *to be*) are called **auxiliary verbs**. There are also auxiliary verbs—such

as could, do, might, mist, ought, shall, or should—that help to frame the nature of an action as necessary, obligatory, or possible. Consider the difference between “You have learned valuable research skills,” and “You could have learned valuable research skills,” or “You must learn valuable research skills.”

Verbals (or non-finite verbs) are a subcategory of verbs. Verbals look like verbs—and indeed they are verbs in form—but they function grammatically as something else, either modifiers (adjectives or adverbs) or nouns. They will always be in one of three forms: infinitives (*to smoke*), present participles (*smoking*), or past participles (*smoked*). To determine a past participle form, think of the past tense form you would use in conjunction with the auxiliary verb *had*, per the example of the past perfect tense in the chart above. Thus, for the verb *to speak*, the past participle is not *spoke*, but rather *spoken*—as in “I had spoken.”

Infinitives can be used as either nouns or modifiers. In the adage “To err is human; to forgive is divine,” the subject in each clause is an infinitive (i.e., *to err* and *to forgive*). Thus, in both clauses, we have an infinitive acting as a noun. In the sentence “Dr. Jorgensen loves to teach,” an infinitive verb form is again acting as a noun, this time a direct object of the main verb *loves*. Here, *to teach* is a thing, conceptually. To prove it, you can swap the verbal out for a concrete noun, such as *cats* or *books* (which are both quite obviously things). In this sentence, *to teach* is a noun, in function; it’s just that it is trickier to conceive of as such because it looks like a verb in form. For an example of an infinitive acting as a modifier, consider the sentence “John went to the library to study for his Public Determinants of Health final.” Here, the infinitive *to study* tells us why John went to the library. And because it answers *why?* it acts as an adverb. In the sentence “Wednesday night is always his night to study,” the infinitive again acts as a modifier, but this time an adjective. It answers the question *which one/what kind?* in relation to the noun *night*.

Similar to infinitives, **present participles** can be either nouns or modifiers. When we write that “Dr. Jorgensen made very good use of online teaching resources,” we are using an *ing* verb form (“teaching”) as an adjective modifying the noun “resources.” In the sentence “Feeling anxious about his exam, John had not slept much in the past few days,” the present participle begins a verbal phrase that acts as an adverb telling us why John had not slept. And when we write that “Smoking has long been considered a health hazard,” or “Dr. Jorgensen loves teaching,” we are using in each instance an *ing* verb form as a noun: *Smoking* is the subject in the first sentence, and *teaching* is the direct object in the second. Conceptually, in both examples the *-ing* verb form names a thing. When present participles are used in this way as nouns, they are referred to as **gerunds**.

Unlike present participles, **past participles** will only function as modifiers. Consider this sentence: “At long last, the undrafted shortstop signed with a professional team.” In this construction, *undrafted* modifies *shortstop* (a noun). Thus, it functions as an adjective.

Prepositions

These are connecting words that link (pre-position) a noun or pronoun (referred to as the object of the preposition) to another word or group of words in a clause. Necessarily, then, they should always be followed by a noun or pronoun. Together with their objects, prepositions make prepositional phrases, which work as modifiers. For example, in the sentence “Hearing a bed alarm go off, the nurse manager ran quickly down the hall,” the preposition *down* plus the accompanying noun (object) *hall* (and that noun’s modifier, the article *the*) combine to create a phrase that functions as an adverb telling us where. Often, prepositions are words of spatial or temporal position—*behind*, *above*, *into*, *to*, *from*, *under*—and that fact can offer a useful way of recognizing prepositions. There are, however, many prepositions that don’t fit into that positional category and may thus be more difficult to recognize, including some that are compound (i.e.,

more than one word): *according to, apart from, as, aside from, beyond, by, concerning, due to, for the sake of, like, in spite of, of, throughout, until, with reference to, among others.*

Conjunctions

Like prepositions, conjunctions are linking words, and they are divided into two groups: those that join sentence elements of equal grammatical weight and/or conceptual importance (so words to words, phrases to phrases, clauses to clauses) and those that join unequal elements, namely subordinate clauses to main ones. The former group are called **coordinating conjunctions**. There are only seven of them, and they can be remembered by way of the wince-inducing acronym FANBOYS: *for, and, nor, but, or, yet, so*. The latter group, **subordinating conjunctions**, are far more numerous. Among the most common are *although, because, since, though, unless, until, whatever, when*. You may note that *unless* inhabits both this list and the list of common prepositions; *since* does as well. When these words are acting as subordinating conjunctions, they will be followed by a clause (e.g., “I have loved that band since they put out their most recent album”). When they are prepositions, they will be followed by nouns (objects) and create modifying phrases: “I have been trying to get tickets to see them live since yesterday.”

Subordinating conjunctions are used to articulate relationships of time (*after, before, since, when, while*), conditionality (*if, unless, whenever*), cause and effect (*because, since*), or concession (*although, despite, even though*). Student writers may sometimes confuse conjunctive adverbs (such as *therefore* or *however*) with subordinating conjunctions since both types of linking words have a similar conceptual function of defining particular logical relationships between clauses. When unsure, the test to determine whether you are dealing with a conjunctive adverb or a subordinating conjunction is to try moving the linking word in question somewhere else in the clause it introduces. As demonstrated above (p. 119), due to their adverbial nature, conjunctive adverbs can be relocated within a clause, and the clause will still make sense. By way of demonstration, let’s look at two sentences that say more or less the same thing, the first using a conjunctive adverb, the second a subordinating conjunction:

Monica took several writing and speech courses; therefore, she is a more confident communicator with both patients and colleagues. (OR “She is, therefore, a more....”)

The linking word here can be moved, and the clause still works grammatically. This confirms we’re dealing with a conjunctive adverb.

Monica is a more confident communicator with both patients and colleagues because she took several writing and speech courses.

The second clause here cannot be rewritten as “she took because several ...” or “she took several writing and speech courses because.” Neither construction makes sense or maintains grammatical integrity. Since *because* has to stay where it is at the beginning of the clause, we know it is a subordinating conjunction.

Correlative conjunctions are two-part conjunctions of which the second part will always be or include a coordinating conjunction: *both ... and; either ... or; neither ... nor; not only ... but also*. In terms of style, what comes after each half of a correlative conjunction—each of the two things being joined—should be cast in grammatically similar ways to ensure constructions are parallel.

Dr. Jorgensen wants neither to disappoint her students nor to lower her high standards.

In this example, the same sort of grammatical unit—an infinitive (verbal) phrase—gets employed after each part of the correlative conjunction, creating a balanced, parallel construction.

Interjections

These are words indicative of emotional outburst. They have really no grammatical relation to the sentence they precede or interrupt, and, as a result, they are often punctuated separately (frequently with an exclamation point): *Oh! Ouch! Wow! Hey! Oops!* All of the words listed are **interjections** exclusively, but some interjections can also be words from other classes: *Shoot! Fantastic! Amazing! Too bad!* Note that interjections are rarely if ever employed in formal (i.e., academic or professional) healthcare writing, in part because they denote a level of overly conversational informality, not to mention a lack of objective distance that tends in most instances to be inappropriate or undesirable.

PHRASES, CLAUSES, AND SENTENCES

As we have already made reference to in the previous section, when words of different classes are combined together into meaningful units, they create either **phrases** or **clauses**. A clause is a group of words that contains a subject and a verb while a **phrase** is a group of words that is missing one or both of those key components. There are two types of clauses, main (or independent) and subordinate (or dependent). Main clauses express a complete thought and can stand on their own as sentences. Subordinate clauses cannot act as sentences because they express an incomplete thought and thus do not make sense by themselves, despite having the same primary grammatical components as main clauses.

Dr. Jorgensen's attention to fine detail is remarkable. [Main clause]

SUB.

VB.

Although it is not always considered an admirable trait. [Subordinate clause]

SUB. VB. ('IS CONSIDERED')

The primary difference between these clauses is that due to the *although* at the beginning, the second leaves the reader hanging, as it were, with respect to just what is not considered an admirable trait. Thus, the statement seems unfinished. The meaning of the clause is dependent upon more information being provided (in the form of a main clause), hence the alternate terms of dependent/independent. Grammatically, subordinate clauses will always be signalled by some marker of subordination—a subordinating word—located before the subject. In the example here, that marker is a subordinating conjunction (*although*). Relative pronouns (*that, which, who*) constitute the other type of subordinating word.

Like subordinate clauses, phrases can also never stand on their own as sentences, but not for the same reasons. While subordinate clauses have everything they need to be sentences (a subject and a verb), phrases have only one of the required components, and often none. There are many types of phrases, all of them working to modify and/or provide additional detail. As we have seen, prepositional phrases function either adjectivally or adverbially, and the same can be said for verbal phrases, which begin with either an infinitive or a participle (past or present). There can also be noun phrases. Gerunds, for example, begin phrases that function as nouns, and infinitives can too. A complete subject (the simple subject plus its modifiers) is also a noun phrase, as is an **appositive** phrase, which is a group of words that comes immediately after a noun in a sentence and works to identify, restate, describe, or explain that noun.

At the beginning of their first term, bright-eyed incoming nursing students have little idea of what awaits them. [Prepositional phrase (adverb)]

To win the lottery would be a dream come true for most people. [Infinitive phrase (noun-subject)]

Shaking uncontrollably, Angela called 911 when she discovered her father collapsed on the floor. [Present participial phrase (adjective)]

I find the tedium of answering telephones all day unbearable. [Gerund phrase (noun-object of preposition)]

Dr. Jorgensen, an award-winning teacher, rarely had any open spots in her classes. [Appositive phrase (noun)]

Sentences can be categorized into four different types according to their structure.

Simple sentences consist of one main clause.

Yet again, the Blackhawks are Stanley Cup champions.
[MAIN CLAUSE]

Compound sentences consist of two (or more) main clauses.

The Blackhawks are Stanley Cup champions, and all of Chicago celebrates.
[MAIN CLAUSE] [MAIN CLAUSE]

Complex sentences consist of one main clause and at least one subordinate clause.

The Blackhawks will likely be favourites next season because they won
[MAIN CLAUSE]

the Stanley Cup again.
[SUB. CLAUSE]

Compound-complex sentences consist of two (or more) main clauses and at least one subordinate clause.

Chicago hockey fans had little hope their team would do well this year, so
[MAIN CLAUSE]

when the Blackhawks won, their victory was all the more rewarding.
[SUB. CLAUSE] [MAIN CLAUSE]

Note that the number and kind of clause in each sentence are what determine sentence type; the presence or absence of phrases has no bearing. Effective writers will strive always for variety in sentence types and lengths. Most documents should include some examples of all sentence types throughout. That said, it is always best to keep in mind the characteristics of your audience in regard to professional and/or educational background and expertise, as those can inform reading level and knowledge of your subject matter. While heavily subordinated compound-complex sentences should not be overused since those constructions are the most difficult to follow, for an expert audience likely to be conversant with the material you are discussing and the type of document you are writing, you can probably get away with employing more challenging syntactical structures without sacrificing clarity too much. Always try to choose sentence types that best fit your content. As the complexity of your subject matter increases, so too might the

need to employ sentences that allow you to articulate relationships between ideas in more subtle and sophisticated ways. And especially if you tend in a given document toward the complex/compound-complex end of the spectrum, keep in mind how some simple sentences in juxtaposition with those longer, more complex ones can seem particularly emphatic and impactful.

PUNCTUATION

The more deeply we immerse ourselves as a culture in social media, text messaging, and other forms of instant electronic communication that limit us to a particular number of characters and/or encourage hastily composed, often fragmentary messages, the less onus there seems to be on needing to punctuate correctly (or at all). In any sort of formal writing context, however, punctuation truly can make or break the success of a document. Frequent and/or serious mispunctuations do much to damage the credibility of the writer—her ethos—and to undermine the clarity and quality of her writing. There is perhaps no more useful and transferrable skill to acquire as a writer than that of being able to punctuate within and between your sentences accurately, and there is also no skill more easily acquired, as this portion of the chapter hopes to demonstrate.

Commas

Commas are the most frequently used and most versatile form of punctuation. They are almost certainly the most misused as well, and the nature of that misuse tends in main to be in employing commas too liberally and indiscriminately. What follows is a brief overview of instances where commas are required. As a general point of commonality, commas mark some sort of break (conceptual or grammatical) in all of the cases. Use commas only in these contexts and try not to overuse them in your writing.

1. Use a comma to separate main clauses linked by a coordinating conjunction.

Hector was displaying flu-like symptoms, so he had to wear a mask in the waiting room.

Note that when both main clauses are short and there is no potential for confusion, some writers prefer not to employ a comma here, particularly in more informal documents. In any sort of formal written communication, however, this rule for comma use is non-negotiable. Remember too, commas never separate main clauses that don't have a coordinating conjunction between them.

2. Use a comma to set off introductory elements from a main clause. As illustrated below, an introductory element can be any sort of phrase (or an adverb) that precedes a main clause and modifies something in it.

Unfortunately, Hector was sent home without being treated. [Adverb]

Near the park where my son plays, the city is opening a new recycling depot. [Prepositional phrase]

Betrayed by overweening pride, Icarus made the fatal mistake of flying too close to the sun. [Past participial verbal phrase]

This rule also applies to complex sentences in which the subordinate clause precedes the main.

After the party ended, Dawn went straight home. (Note that such a construction requires no comma when the order of the clauses is reversed: "Dawn went straight home after the party ended.")

3. Use commas to separate words/phrases in a series or list.

Medical school applicants require high marks, strong reference letters, and top-level MCAT scores.

A rather large, heavy volume of early modern poetry lay open on his desk.

In the first example, noun phrases are listed, and in the second, adjectives. Be careful, however, to distinguish between coordinate adjectives, which require commas, and cumulative adjectives, which don't. While coordinate adjectives each modify the noun equally (i.e., it is a heavy volume just as much as it is a large volume) and as such can be put in any order (*large, heavy* or *heavy, large*), cumulative adjectives are listed in an order that can't change, since they don't modify the noun equally. For that reason, they do not require commas.

Jessica's mother acquired the leases for two new antique stores.

This construction cannot be rewritten with the adjectives in any other order, so commas are not used. The adjective *antique* modifies the noun *stores*, while *new* modifies *antique stores*, and *two* modifies *new antique stores*. If you are confused as to whether listed adjectives are coordinate or cumulative, try changing their order. Does *new two antique stores* work? Does *antique new two stores*? Similarly, try putting the coordinating conjunction *and* between the adjectives; if you can, they are coordinate and require commas: *large and heavy* is okay in a way that *two and new and antique* is not.

One thing more: note that a comma is still required before the final list item in a list of three or more items, even when that item is preceded by a coordinating conjunction (i.e., *and*), as in the example "high marks, strong reference letters, and a top-level MCAT score." The final comma in such constructions is referred to as a serial (or Oxford) comma, and its use is a matter for debate that tends to be informed by personal preferences. Serial commas should be employed in formal writing of all types; punctuate a list of three or more items the same way always, regardless of whether or not a coordinating conjunction precedes the last item. Still, writers should be aware that they may encounter resistance to the use of serial commas from time to time, depending on the reader.

4. Use commas to set off non-restrictive (or non-essential) information from the rest of a clause.

Non-restrictive information describes or modifies a noun or pronoun that is already clearly defined and specific. It adds additional colour or detail to the clause, but it is not at all a necessary element; if you remove it, the noun/pronoun to which it refers will still denote exactly the same thing. It won't all of a sudden become generic or imprecise in what it denotes, which is the case when restrictive (or essential) information is removed.

Explosions in the Sky, an Austin-based instrumental band, recently released yet another very well-reviewed album.

In this example, the underlined appositive phrase is non-restrictive: while it provides information about the subject (Explosions in the Sky), that information, while perhaps useful to readers who don't know anything about the band in question, is not essential to narrowing down the range of possible meanings for "Explosions in the Sky." If it is removed from the sentence, there won't be

any confusion as to who or what the writer is referring to: it will still be the band Explosions in the Sky. Here's another example:

Joe's tire repair shop, which is located in the south end of the city, has an excellent reputation.

In this sentence, the underlined subordinate clause provides non-restrictive information about Joe's tire shop. If that information were removed, the sentence would still be about Joe's tire shop, a specifically named thing. The underlined information does nothing to help us identify which tire shop is in question; we know it is Joe's. In both examples here, the commas help to indicate the nature of the underlined sentence elements as unnecessary and additional—as extra to the sentence, almost like an aside. In fact, both constructions could be set off with either parentheses or dashes, a fact which might help to underscore their ancillary, non-essential nature.

Let's write the previous sentence in a slightly different way, this time using restrictive information.

The tire repair shop that is located in the south end of the city has an excellent reputation.

A Common Point of Confusion: That vs. Which

Many writers treat the relative pronouns *that* and *which* interchangeably. And, indeed, both words do serve the same grammatical function of introducing a subordinate clause that provides modifying information. However, there is an important difference between the sort of information each word introduces. To wit, (and as a couple of examples in this portion of the chapter have already indicated) *that* is used to introduce restrictive clauses while *which* is used to introduce non-restrictive ones.

The MCAT is a standardized test that all would-be physicians must take.

The MCAT, which I have scored poorly on multiple times, is not an accurate indicator of whether someone is well-suited to a career as a healthcare provider.

Generally speaking, use *that* in constructions that don't require commas, *which* in constructions that do.

Here, the underlined information is not set off with commas because it provides a detail that is necessary to our understanding of the sentence: it is restrictive or essential information. Were the subordinate clause to be removed from the sentence, what's left would read "The tire repair shop has an excellent reputation." What tire repair shop? The detail about its location doesn't necessarily identify the specific shop in question, but it certainly does narrow down the range of possible options significantly, and that's why it is termed restrictive: it restricts the meaning of the noun it modifies in a more precise way.

5. Use commas to set off transitional expressions.

Logical markers such as conjunctive adverbs and prepositional phrases require punctuation on either side of them, one mark of which will always be a comma. When those transitional expressions are used as sentence interrupters—that is, when they come in the middle of a clause—they will be both preceded and followed by commas.

North Americans have not been getting healthier. People on average eat several hundred calories more per day than they did in the late 1980s, for example.

There are many significant health problems associated with Vitamin-D deficiency; most of them are wholly preventable, however, by way of some minor changes to one's eating habits.

6. Use commas after a verb of speaking to introduce a quotation.

Verbs of speaking name an act of speech or writing: *says*, *states*, *posits*, *writes*, *argues*, *wonders*, *theorizes*, *asks*, *insists*, *claims*, etc. And whether a quotation comes before or after such verbs, the punctuation with a comma remains consistent.

In concluding the narrative opening of her still-influential book *Silent Spring*, environmental scientist Rachel Carson asks, "What has already silenced the voices of spring in countless towns in America?"

"No witchcraft, no enemy action had silenced the rebirth of new life in this stricken world. The people had done it themselves," writes Carson.

This particular convention of comma use is a bit counterintuitive, since in any other context we do not put commas between transitive verbs (which verbs of speaking are in these situations) and their direct objects. We don't, for instance, write that "He failed, his MCAT," or "I gave, a book to my wife." Note too that the combination of verb and comma is far from the only way to introduce a quotation. But be wary of falling into the trap that many student writers do of employing a colon after the verb in these sorts of constructions. Though quotations can be introduced by way of a colon, they cannot be if a verb of speaking is employed.

7. Use commas to set off nouns of direct address.

Statements that give commands or make requests are referred to as imperatives. Usually, the subject in such statements is understood to be *you*, since context dictates that commands or requests need to be directed at someone (or a group of people). Thus, in most imperative constructions, the subject is omitted but implied.

Open the back door to let the cat out. [Implied subject is *you*.]

Sometimes, the name of the person to whom a command or request is being directed will be given, for reasons of clarity or emphasis. When that happens, the name of the addressee (the noun of direct address), will be set off from the rest of the clause with commas.

Evan, please go upstairs to brush your teeth.

Please, Evan, go upstairs to brush your teeth.

Please go upstairs to brush your teeth, Evan.

8. Use commas to set off words or phrases at the end of a sentence when they express contrast or pose questions.

That is not what Dr. Jorgensen asked us to do, is it?

She requested that we submit our annotated bibliographies in class, not electronically.

9. Use commas to separate parts of a date or an address.

Classes are scheduled to resume on Wednesday, September 3.

He recently moved to 31 Fairbush Avenue, Unionville.

Semicolons and Colons

Semicolons are stronger marks of punctuation than commas, and they are far less flexible, thus easier to use (in theory). Really, there is just one way in which a semicolon can be employed correctly, and that is to join two closely related main clauses.

I am not a doctor; I just play one on television.

Semicolons create balanced compound sentence constructions in which what is to the left of the semicolon and what is to the right are grammatically equivalent elements (specifically, main clauses). Semicolon constructions sometimes work best when the main clauses are relatively short. And because such constructions help to establish and underscore a close conceptual relationship between the linked clauses, semicolons will often be employed alongside logical markers, such as conjunctive adverbs, that do the same thing.

My biology lab partner is new to our university; moreover, she is an international student unfamiliar with the language and culture.

The test to see whether or not you have employed a semicolon correctly is an easy one. Ask yourself if the clause on either side can stand on its own as a sentence; if so, then a semicolon works (assuming that some sort of conceptual connection exists between the clauses as well). There is, however, one instance in which you may use semicolons to do something other than link main clauses. When you are listing two or more clauses or phrases in a series, and those clauses or phrases are already punctuated, semicolons may then be used to distinguish between each list item since they provide a clearer visual distinction between where one clause/phrase ends and the next begins.

John enrolled in Dr. Jorgensen's introductory neurobiology class along with Ryan, his best friend; Allison, Ryan's girlfriend; and Stacey, Allison's new roommate.

If this construction were to be punctuated as a list of nouns normally would, using commas, it would be extremely difficult to tell which elements were appositive phrases describing the people named, and which were the nouns actually being listed. Semicolons provide a necessary visual separation between the noun and appositive phrase pairings that comprise each list item, and they make for a clearer, easier to read sentence.

Colons are employed to create unbalanced constructions, unlike semicolons. That is, what precedes the colon will (usually) be a main clause, while what follows the colon (usually) won't. Their function is one of introduction or establishing expectation; they indicate that what follows will explain, elaborate upon, or amplify the preceding clause. Specifically, use colons to introduce lists, appositives, or quotations (in lieu of verbs of speaking).

List: These are the things I need at the grocery store: milk, eggs, bread, cheese.

Be careful not to split up a verb and its object (i.e., "The things I need at the store are: milk, eggs, bread, cheese"). Colons don't follow verbs. Also, don't make the other common mistake of splitting up prepositions and objects, as in "In his moment of distress, he thought of: his wife, his children, his parents."

Appositive: That new nurse demonstrates two important qualities for success: punctuality and an ability to communicate clearly.

Quotation: Consider Ric Flair's famous boast: "To be the man, you've got to beat the man. And, brother, I am the man." (But not "As Ric Flair famously boasted: 'To be....'"")

Some writers feel it is fine to employ a colon after verbs of speaking if the quotation that follows is long, though just what the definition of "long" is in such circumstances isn't necessarily clear or consistent. In the end, consistently following the rules outlined in this chapter—comma before a quotation after a verb, colon before a quotation after a main clause—will avoid any confusion and always ensure correct punctuation.

Dashes

Like colons, dashes (properly called em dashes, to distinguish them from en dashes, which are mostly used in denoting date ranges, for example 1980–2010, or page ranges) can introduce grammatical elements that are unequal to what precedes the punctuation (which will often be a main clause). They can also be used to mark an interruption, insertion, or aside. The one thing they will tend not to do, however, is link main clauses. They are interchangeable with colons in some instances, and commas or parentheses in others, though never semicolons. Choose a dash when you want to provide greater emphasis to a particular construction; they are punchier and more dramatic than the other pieces of punctuation that might function similarly. For that reason though, you will want to use dashes in moderation, as any dramatic effect they may provide will be dependent on your not overusing them.

Here are the contexts in which dashes are most useful:

1. Setting off and drawing attention to a sentence interrupter.

Molly had volunteered—actually, she had been told—to organize the team retreat at the end of the summer.

2. Introducing lists or appositives, particularly (for the sake of clarity) when those appositives contain commas.

The qualities Dr. Jorgensen displayed as a teacher—exceptional patience, a willingness to challenge her students, an abiding desire to see them succeed—were rare in combination.

Before going to the cottage next week, we need to get a lot of stuff—some groceries, new bathing suits, beach toys for the kids, sleeping bags.

Note that dashes (unlike colons) may also be used in constructions that begin with lists:

Groceries, new bathing suits, beach toys for the kids, sleeping bags—these are the things we need to get before going to the cottage next week.

Some think dashes too informal for professional or academic prose, but that is something of a retrograde opinion. They are perfectly acceptable to use in all types of writing, assuming they are used appropriately and correctly.

Apostrophes

Apostrophes are used primarily to mark nouns in the possessive case (indicating ownership).

Dr. Jorgensen's students love going to class.

Add's or an apostrophe only to form the possessive of singular nouns ending in -s. Add only an apostrophe to form the possessive of plural nouns ending in -s.

James's doctor (or James' doctor) referred him to an orthopedist for an assessment.

University lecturers' incomes have barely risen over the past decade or so.

Be wary of situations in which there is more than one possessor named though. Always consider the context: is it a situation of individual or joint possession? In the case of individual possession, put an apostrophe -s or apostrophe only (where appropriate) at the end of each named possessor. In the case of joint possession, since there is collective ownership of something, treat the multiple possessors as one group and employ the apostrophe -s (or apostrophe only) after the last-named owner.

Milton's and Marvell's political values were similar. [Individual possession: Milton and Marvell had separate, if similar, sets of values.]

The patient recovered as a result of her doctors and nurses' excellent post-operative care. [Joint possession: Doctors and nurses are equally responsible for "excellent care."]

Apostrophes also mark where letters have been omitted in contractions (i.e., can't, won't, wouldn't, it's, aren't, ...). While contractions are acceptable in informal modes of communication, they should be avoided in formal (academic and professional) healthcare writing contexts. Remember, however, that pronouns have possessive case forms that never require an apostrophe (his, her, their, your, my). To take one important example, the possessive case form of the pronoun *it* is *its*, not *it's* (which is a contraction of *it is*). Be vigilant about avoiding this common point of confusion.

Remember also that apostrophes never indicate plurals (except in the reasonably rare cases of letters used as letters or words used as words).

There are too many *p's* in that word.

It used to be the case that plural forms of abbreviations and numbers required apostrophes. Contemporary usage employs just the -s in such constructions though (i.e., RNs, MDs, 1950s).

AVOIDING COMMON ERRORS OF GRAMMAR AND STYLE

There are potentially any number of errors with respect to both grammar and style that can find their way into your writing at the expense of clear expression, and it is not our purpose here to enumerate and explain them in an exhaustive way; indeed, to do so is well beyond the purview of this chapter. Instead, we have chosen to focus on errors that fall within six common categories and to build on the preceding discussions of grammar and punctuation basics in explaining how to recognize and correct such problems if and when they arise. Healthcare practitioners and students work in closely collaborative environments. Being able to recognize and eliminate writing errors quickly and efficiently is a very valuable skill to have not only as a writer but also as a colleague of other writers whose work you may be asked to read, review, and edit.

Agreement Problems

There are two types of agreement in sentences with which writers need to be familiar: subject-verb and pronoun-antecedent. Verbs must always be made to agree with their subjects in person (first, second, or third) and number (singular or plural). The first step towards preventing or

eliminating problems of subject–verb agreement is to revisit the difference between complete and simple subjects, since it is the person and number of the simple subject that determines the correct form of the verb.

[SIMPLE SUB.]

The new **administrators** at our hospital have decided to reintroduce split shifts for nurses.

[COMPLETE SUB.]

[VB.]

In this example, the underlined complete subject consists of the bolded simple subject *administrators*—the single noun naming who or what the clause is about—plus all of its modifying words and phrases. In order to determine whether the verb form in the clause is correct, determine first what noun constitutes the simple subject, then figure out the operative person and number. Here, *administrators* is third person (the administrators = they) and plural. The verb is in the present perfect tense, so while the past participle *decided* works with any number, it is the form of the auxiliary verb that matters: *have* is third person plural (they have), so it agrees. The potentially tricky thing about this example is the singular noun *hospital*, which is the object of the preposition *at*, because it occurs after the subject and right before the verb. As such, some more careless writers may want to make the verb agree with it. In such situations where there is more than one noun in the subject portion of the clause, be vigilant about ensuring you know which one is the actual (simple) subject; any others don't matter as far as agreement goes. And remember too, though it is counterintuitive for some, -s forms of verbs are singular, not plural.

The quick brown fox jumps over the lazy dog. The quick brown foxes jump over the lazy dog.

[SINGULAR SUB./VB.]

[PLURAL SUB./VB.]

There are several scenarios in which subject–verb agreement may seem not so straightforward, so agreement problems can tend to arise. Here is what you need to know in order to deal with such situations.

i. Compound subjects (two or more simple subjects joined with *and*) are usually considered plural, and they take a plural verb accordingly.

Andrew and Rahman often golf together.

An exception to this rule occurs if the linked simple subjects refer to the same person or thing, as in “Dr. Jorgensen’s friend and colleague regularly joins us for lunch,” or “Peanut butter and jelly is her favourite sandwich.” The first example here assumes that Jorgensen’s friend and colleague are the same person. If those nouns refer to two different people, of course, a plural verb would be required, per the usual practice with compound subjects: “Dr. Jorgensen’s friend and colleague regularly join us.” Note that in practice, such a sentence would precede each noun with a possessive pronoun to render unambiguous the fact that two separate people are being referred to (i.e., “Dr. Jorgensen’s friend and her colleague....”).

When compound subjects are preceded by *each* or *every*, they take singular verbs. When they are followed by *each*, however, they are considered plural.

Every patient, family member, and caregiver has a voice worthy to be heard.

The patient and caregiver each have different stressors that must be recognized.

ii. Collective nouns name a class or group of things. More often than not, they are singular and take singular verbs, as the emphasis tends to be on the idea of the unit or group as a whole.

Any rock band plays well after touring so much.

You can, though, use a collective noun to refer to the individual members of a group. In such cases, a plural verb form is used.

That band do not agree on what city to play next (i.e., the band members do not agree).

In this example, the onus is not on the group as a unit but rather on the members comprising that group since the sentence refers to their disagreeing with each other (denoting that they are not, here, a single unit).

iii. Watch for nouns ending in -s that refer to a single thing, titles that look plural, or gerund phrases ending in -s: all are singular.

Thanks to a decline in vaccination rates, measles is a disease now on the rise.

Aldridge and Associates is a new PR firm that opened up down the block.

Placating angry clients is an aspect of this job that no one likes.

iv. When a prepositional phrase follows the subject, make the verb agree with the subject (as always), not with the object of the preposition though it may differ in number from the subject and be closer in proximity to the verb. In the example below, the singular verb *wants* agrees with the singular subject *doctor*, not with the plural object *oncologists*.

John's family doctor, in consultation with his oncologists, wants to think about some new treatment options.

Pronouns must agree with their antecedents in person and number, as well as gender (masculine, feminine, neuter). As with subject-verb agreement, there are some situations similar to those discussed above in which it can be a bit more difficult to figure out which pronoun to employ.

i. Indefinite pronouns (*all*, *anyone*, *each*, *either*, *nobody*, *one*, *something*, etc.) are generally thought of as singular, and they must not be referred to by plural pronouns.

In our writing class peer review sessions, everyone works at his or her own pace.

Note here that the use of the non-gender specific singular *his or her* implies a class of both male and female students. Were the class all women, then *at her own level* would be correct. In either case (and despite the use of *they* as a singular pronoun having now started to gain some wider support), the plural possessive *their* should be avoided in formal writing, though it sounds preferable to many.

ii. Collective nouns are thought of as singular antecedents, unless the focus is on the members comprising the group (as in the second example below).

The contract faculty committee voiced its resistance to the proposed agreement.

The contract faculty committee have differing opinions as to why they need to be concerned with the proposed agreement.

iii. Most compound antecedents are referred to by plural pronouns, with the same exceptions noted above (i.e., when they refer to the same person or thing).

Dr. Jorgensen's friend and a colleague have offered their help.

Dr. Jorgensen's friend and colleague has offered his help.

A note on pronoun use and inclusive language: be sure when you are making general statements that you employ gender-neutral language. In this book, when we refer to *the writer* or *the practitioner* or *the patient* in any given instance, we alternate between the pronouns *he* and *she*, simply to avoid the unwieldiness of having too many *he or she* constructions. If you are averse to using *he or she*, you can use plural nouns as antecedents when making general statements; that way, you can use the gender-neutral *they*.

Non-inclusive: A new nurse should always be ready to work longer hours than she might expect.

Inclusive: New nurses should always be ready to work longer hours than they might expect.

Sentence Boundary Errors

There are two varieties of sentence boundary error: fragments and run-ons. Both are considered equally serious, as they suggest that a writer lacks the essential understanding of what constitutes a main clause and/or of how such clauses can be joined together correctly. We know that at the very least, a simple sentence must consist of a single main clause. A **fragment** is a construction that is punctuated and passed off as a sentence despite not being (or having) a main clause. We speak using fragments all the time, as well as send text messages, tweets, and casual emails similarly fragmentary in nature (You there yet? Leaving now. Me too.), and we do so without usually compromising clarity or intent. In terms of formal writing, however, fragments are wholly unacceptable; the expectation is always that you will write in complete sentences.

But how do you recognize a fragment in your writing in order to correct it? There are three questions you can ask to determine the completeness of any sentence construction you think could be fragmentary:

1. Is there a subject?

Remember that the subject of an imperative (e.g., "Do your homework.") will usually not be stated, but it is implied and understood to be "you." This possible exception aside, the subject should be relatively easy to identify. If there is no subject, then you have a fragment on your hands and need to revise. Assuming there's a subject, though, you can move on to the next question.

2. Is there a verb?

Do not mistake main verbs for verbals—infinitives or participles that are acting as nouns or modifiers. In the fragmentary construction "The first-year nurses talking," there is a subject but no verb, as the present participle *talking* would require an auxiliary to be made into a main verb (i.e., "The first-year nurses had been talking"). If there is no verb, then you have a fragment and need to revise. If there is a verb, then you can go on to the last question.

3. Is the group of words in question a subordinate clause?

Look to the left of your identified subject: is there a subordinating conjunction or relative pronoun there? Sentences can of course begin with subordinating words, provided the clauses they introduce are attached to main clauses (to create a complex or compound-complex sentence). When we are discussing possible fragments here, however, we are imagining that in almost all instances you will be looking at a group of words consisting of at most a single clause.

If your clause begins with a subordinating word and is not part of a larger construction that features a main clause, then you have a fragment and need to revise. If it doesn't, and if you've answered yes to the previous two questions, then you have a complete sentence (though something else could certainly be wrong with it grammatically or stylistically that makes it sound not quite right to you. Further investigation may be in order).

Having identified a fragment, how do you revise your construction to eliminate the problem? There are two main ways. Either attach the fragment to a nearby main clause or put in the missing subject or verb that will make the fragment a main clause. In the case of a subordinate clause on its own, you could also simply eliminate the subordinating word. In the end, you need always to do what works best at that particular moment in your document, with a view to maintaining clarity as well as maintaining variety with respect to sentence length and type.

Run-ons are two (or more) main clauses incorrectly joined together. Though many student writers use the term "run-on" to refer simply to overly long sentences, grammatically a run-on is always either a comma splice or a fused sentence. In a comma splice, main clauses are joined together with a comma only, and in a fused sentence, main clauses are joined together with no punctuation at all. As with potential sentence fragments, any sentence you think may be a run-on can be checked for whether or not it is in fact a sentence boundary error by asking three questions:

1. Are there at least two main clauses present?

If there aren't, then by definition you can't be dealing with a run-on. If there are, however, then ask ...

2. Are those main clauses joined by a comma and a coordinating conjunction?

If so, then your compound sentence is correctly constructed. If not, you still don't necessarily have a run-on. You need to ask one more question.

3. Are those main clauses joined with a semicolon?

If they are, then the sentence isn't a run-on. If they aren't, you now know that you have a run-on and need to revise. There are several options for revision, and again, a combination of personal preference and contextual awareness should guide your decision as to which option is most effective.

Think back to the assessment questions you just asked, since those can point to a couple possible ways to revise. You can use a comma and a coordinating conjunction between clauses (which works well for comma splices, since only the conjunction is missing). Alternatively, you can link the clauses with a semicolon (which works well if both main clauses are short; the expectation of their being closely conceptually related is likely not an issue, since the fact that they are combined together in the first place—if incorrectly—suggests a similarity in content). Your other options are to rewrite the compound sentence as a complex one, making one clause subordinate to the other, or you can separate the clauses into two simple sentences. Stylistically, this last is the least preferable in most instances, though fixing the sentence boundary problem needs to be job one, and all of the options serve equally in that regard. Below are examples of the various ways in which a run-on—here a comma splice—might be revised and corrected.

Run-on: Stephanie was an excellent nursing student, she now wants to try medical school.

Revisions:

Stephanie was an excellent nursing student, so she now wants to try medical school. [Comma + coordinating conjunction]

Stephanie was an excellent nursing student; she now wants to try medical school. [Semicolon]

Because Stephanie was an excellent nursing student, she now wants to try medical school.
[Complex sentence]

Stephanie was an excellent nursing student. She now wants to try medical school. [Two simple sentences]

One last note about comma splices in particular: remember that when a conjunctive adverb (such as *however* or *therefore*) comes between clauses, those clauses are both main. That means you cannot simply put a comma before the conjunctive adverb in such constructions as that would be a comma splice. This particular mispunctuation is perhaps the main cause of sentence boundary problems in student writing.

Run-on (comma splice): Stephanie was an excellent nursing student, therefore, she now wants to try medical school.

Correction: Stephanie was an excellent nursing student; therefore, she now wants to try medical school.

[As noted earlier on in this chapter, semicolons work particularly well in such constructions, since they underscore the close relationship of the clauses. Separating this run-on into separate sentences, the second one beginning “Therefore, she ...,” would work as well, though.]

Modifier Problems

Modifiers, whether single words or phrases (or subordinate clauses), must have an immediately apparent relationship to the words they are modifying in a sentence. Problems of clarity arise when a reader cannot easily connect a modifier to what it is supposed to modify. In such instances, the modifier is said to be misplaced. Location of modifiers within sentences is a concern of syntax, and syntax falls under the aegis of style. A misplaced modifier, therefore, is a category of stylistic error, and it is one that accounts for problems related to several different modifier types.

Limiting modifiers (e.g., *almost*, *even*, *exactly*, *hardly*, *just*, *merely*, *only*, *scarcely*, *simply*, *not*) are adverbs that modify what follows them immediately. If they are located too early on in a sentence, just what it is they are supposed to be modifying—and thus the meaning of the sentence—becomes unclear. While the example below is not grammatically incorrect, exactly what idea the writer is trying to express remains unclear due to the location of *only* before the main verb.

Misplaced: Dr. Jorgensen and her friend only talked to each other in the summer, after the term had ended.

Depending on what you understand the intended meaning to be, here are the potential revisions for clarity:

Dr. Jorgensen and her friend talked only to each other in the summer, after the term had ended.

Dr. Jorgensen and her friend talked to each other only in the summer, after the term had ended.

Dr. Jorgensen and her friend talked to each other in the summer, only after the term had ended.

Each sentence says something different, and the variation between sentences is wholly a function of moving the limiting modifier to a position immediately before the word(s) you intend it to modify. Employ modifiers in a manner that allows you to say precisely what you want.

As a general rule, readers will tend always to link modifying phrases and clauses to the nearest word that could possibly be modified. Be sure, then, to locate phrases/clauses in such a way as to ensure that they modify only the intended words.

Misplaced: The nursing librarian was kind enough to set two reference works on the counter, which we need to look at today.

Misplaced: Dr. Jorgensen could see her students heading to class through her office window.

In the first sentence, the location of the subordinate clause makes it sound as if it is the counter that the nursing students need to look at today, when presumably it should be the books. Likewise, in the second sentence, Jorgensen seems to be able to see her students going to class via a route that takes them through her office window. While both of these sentences are grammatically sound, neither one says what the writer seems to intend wholly as a result of where a modifying clause/phrase has been (mis)placed. In fact, both end up saying something odd and even ridiculous.

Revised: The nursing librarian was kind enough to set two reference works, which we need to look at today, on the counter.

Here, the subordinate clause refers to the reference works, so it needs to be placed in closer proximity to that noun phrase.

Revised: Through her office window, Dr. Jorgensen could see her students heading to class.

The prepositional phrase "Through her office window" works much better up front as an introductory element since it refers to Jorgensen, who is the subject.

When a word or phrase is located in a sentence so that it seems logically to modify equally well the words on either side of it, it is referred to as a **squinting modifier**. The general rule with squinting modifiers is that you correct them by putting the modifier either before the word or phrase to the left or after the word or phrase to the right.

Misplaced: Students who practise writing often see significant positive results.

It is unclear in this example whether *often* applies to *practise writing* or to *see positive results*, as it could just as easily apply to either, and its location doesn't help us.

Revised: Students who often practise writing see positive results (or Students who practise writing see positive results often).

A **dangling modifier** does not logically modify any word in a sentence. Most often, it is a modifying phrase that introduces a sentence and suggests an action or a characteristic of the subject to come without specifically referring to that subject. When the subject of the sentence is then different than the subject implied by the modifying phrase, the introductory modifier dangles, meaning its logical connection to the sentence is made tenuous or non-existent. With

dangling modifiers, it is not so much that the modifying material is misplaced, rather that it doesn't supply all the information needed (i.e., the actual subject it modifies), or that the subject of the sentence as it is written is not the correct one.

Leaving a study session for the upcoming biology exam, Lisa's car battery died.

When still in preschool, my parents relocated our family to Winnipeg.

As it is written, the first sentence suggests that it was the car battery that was leaving the study session, which likely was not the case. And despite how the second sentence reads, it also seems unlikely that the parents were in preschool when they moved. The nature of the modifying material is different in each example—a present participial phrase in the first, an elliptical subordinate clause (meaning a subordinate clause from which material has been omitted) in the second—but the problem is the same: the subject of the sentence is not whom the modifier seems logically to refer to.

Usually, there are a couple of options for revising dangling modifiers. You can either turn the modifying material into a clause that names an appropriate subject, or you can keep the modifier as it is and rewrite the main clause accordingly.

Revised: Leaving a study session for the upcoming biology exam, Lisa discovered that her car battery had died.

Revised: When I was still in preschool, my parents relocated our family to Winnipeg.

Passive vs. Active Voice

The voice of a verb indicates whether the subject of the sentence performs the action (the active voice) or is acted upon (the passive voice). Generally speaking, effective writers should strive to employ the active voice whenever they can, as it makes expression clearer, more direct and engaging, and more concise.

Active: An angry and dishevelled chauffeur drove the limousine.

Passive: The limousine was driven by an angry and dishevelled chauffeur.

To change a passive sentence to an active one, name the verb's actor as the subject, choose an active verb form (i.e., eliminate the auxiliary forms of *to be*), and make the subject of the passive construction into an object.

There are a couple of contexts in which the passive voice is useful, however: when the actor is unknown (and thus cannot be named as the subject), and when the actor is not important. There are particular instances in healthcare writing (and science-inflected writing more generally) that actually demand the use of the passive voice. Typically, any explication of the labour involved in carrying out some point of care (e.g., what was done for a patient) should be in the passive voice. Likewise, so should a reported experiment or course of primary research (e.g., what was done or added to something, what was mixed or calibrated or calculated or collected, etc.). In all instances, the action itself is what is important, and employing passive voice constructions allows us to relegate the agents who carry out the action to a secondary position.

Appropriate Use of Passive Voice: The line was primed and an IV was started.

Appropriate Use of Passive Voice: In the second instance, the extracted cells were then added to the saline solution.

Here, the active voice construction for the second example would be “In the second instance, we then added the extracted cells.... ” And while that is likely true, it isn’t useful information. In something like a “Materials and Methods” section of a report, the reader needs only to know about how the research was carried out, not by whom. As we note later on in this book, there is opportunity elsewhere in even the most science-oriented healthcare writing to employ the active voice, which usually also means employing the first person (*I/we*).

Faulty Parallelism

Parallelism is a similarity in grammatical form between two or more sentence elements (e.g., words, phrases, or clauses) that reflects their close conceptual relationship. Like poetry, parallelism reinforces meaning through form; parts of a sentence given the same function and importance are also given a corresponding grammatical similarity. As with the examples of modifier problems and active vs. passive voice, faulty parallelism is a stylistic rather than grammatical problem. An unbalanced—which is to say, non-parallel—construction will have grammatical integrity; it just won’t convey its meaning in as emphatic and sophisticated a way as it might. Employ parallelism to balance the following sorts of constructions:

i. Sentence elements in series

Non-parallel: Dr. Jorgensen is such an effective instructor because she is always prepared, she cares about her students, and being an accomplished public speaker is key.

Parallel: Dr. Jorgensen is such an effective instructor because she is always prepared, she cares about her students, and she is an accomplished public speaker.

Often in these constructions, writers will employ a similar form for at least a couple of the listed things. The easiest route to revision is then to take the most grammatically dissimilar sentence element—here the last clause—and recast it to bring it in line with the other elements.

ii. Sentence elements linked by coordinating or correlative conjunctions

Non-parallel: In the winter, she likes skiing and to snowboard.

Parallel: In the winter, she likes skiing and snowboarding (or “to ski and to snowboard”).

Non-parallel: As an undergraduate, I learned not only that professors usually have plenty of time for students who seem conscientious but also little patience for those who don’t come to lecture.

Parallel: As an undergraduate, I learned not only that professors usually have plenty of time for students who seem conscientious but also that they have little patience for those who don’t come to lecture.

(or “that professors usually have not only plenty of time for students who seem conscientious but also little patience for those who don’t come to lecture.”)

With correlative conjunction constructions, remember that what comes after the first part of the conjunction (here *not only*) and what comes after the second part (*but also*) need to be grammatically equivalent. One strategy for fixing faulty parallelism in this scenario is to think of the two parts of the conjunction as sliders that you can move back and forth within the sentence until there is a balance between what comes after each. Look perhaps for the part of the

construction that has less grammatical material after the conjunction, and make the other part match that.

iii. Sentence elements in a relationship of comparison or contrast

Non-parallel: Recent research suggests that a growing number of mothers prefer leaving their children susceptible to measles rather than to vaccinate them.

Parallel: Recent research suggests that a growing number of mothers prefer to leave their children susceptible to measles rather than to vaccinate them.

In the end, remember that parallelism is a stylistic device that helps clarify and underscore meaning. As with any element of effective writing, parallel constructions should be employed in moderation only and never overused.

CHAPTER SUMMARY

By this point, you should be able to:

- Identify individual words according to their class and understand how those words work together to create meaningful grammatical units. You should also be able to define both *phrase* and *clause* and to distinguish between them with respect to structure and function.
- Differentiate between main and subordinate clauses and between sentence types as well.
- Understand how and when to punctuate correctly and appropriately, using a full range of marks: commas, semicolons, colons, apostrophes, and dashes.
- Recognize some common types of grammatical and stylistic errors—namely agreement problems, sentence boundary errors, modifier issues, passive voice constructions, and faulty parallelism—and also know how to revise your writing with a view to eliminating these issues.

Some self-check or class discussion exercises you might want to try include the following:

- Select a piece of your own writing, whether something you have handed in previously or (perhaps better) a draft in process. Review it in detail with respect to grammar, punctuation, and style. Go over it first by selecting a paragraph and then identifying each word in that paragraph according to class. Then, go back over that same paragraph with a view to identifying the sentence types you use. Do you strike a note of variety in terms of type and length? Examine your punctuation throughout the document. Do you employ a range of punctuation marks? What, if any, punctuation errors are present, and how can you fix them? Last, (re)consider your piece of writing in light of this chapter's discussion of common grammatical and stylistic errors. Which, if any, of those are present? And again, how might you revise to eliminate them?
- Turn to the “[Chapter 6 Review Quizzes](#)” at the end of this book and use them to help you review and revisit the chapter material, perhaps with a particular focus on issues with your writing that the previous exercise may have brought to light. Answers for each quiz are provided.

Healthcare Research and Academic Writing

(Part 1):

7

Prewriting, Critical Analyses, Reports, and Essays

In this chapter, we turn our attention to the sort of writing that is most immediate and important to anyone enrolled in a healthcare-related program at university or college. There are certainly many different types of documents students may be asked to produce as part of their coursework. Nevertheless, there are some common expectations with respect to content and approach that the readers of such documents—namely, the instructors who assign them—will have. As such, there are some broadly applicable strategies and essential skills that academic writers need to be familiar with in order to be successful. What follows aims to identify those strategies and skills and discuss some useful ways of thinking about the various interrelated tasks and considerations that necessarily go into writing documents that entail some sort of formal research component.

PREWRITING: ASSESSING THE RHETORICAL SITUATION

The several modes of academic writing one can encounter in the course of pursuing a degree or diploma in a healthcare field are as much marked by important similarities as they are defined by fundamental differences. For that reason, we can usefully approach our discussion here by way of a common series of foundational questions that will help us understand generally just what is at stake and to whom in any document. Indeed, these four basic questions should be asked of anything we sit down to write, before we ever put pen to paper (or more likely, finger to keyboard), during the prewriting stage. As we mention back in [chapter 2](#), prewriting precedes the drafting process and involves initial information gathering as well as assessing the [rhetorical situation](#) of the document you are going to write. That is, it involves figuring out the specific context of that document as determined by your awareness of its subject, purpose, audience, and potential limitations.

Question 1: What is my subject?

What am I being asked to write about, or what do I want to write about, if I have the freedom to choose? What is my topic? Note that your topic differs from your subject in terms of focus. While the subject is going to be a broad, general articulation of what it is your document will address, the topic will constitute a decidedly narrower understanding of and statement about your subject matter. Say the assigned task is to write a scholarly essay examining how the prenatal care a woman receives affects the health of her newborn. In that scenario, your (broad) subject would be prenatal care and newborn health; your (narrower) topic might be something like the link between an absence of prenatal care and low birth weight (since the assignment seems to allow for a focus on either positive or negative health consequences).

To make the necessary move from subject to topic, you may have to engage in a course of preliminary research and reading to get some feel for what is out there with respect to your

general subject. Giving yourself some sense early on of what others have said about a subject can go a long way toward helping you start to focus in on a particular aspect. It can also give you a bit of a head start on finding some sort of position to take—something about which you can make an assertion—if (looking ahead to the next question) you are being required to write an argument. The particulars of such a position are matter for a thesis statement that will narrow down your topic even further, with much greater precision and detail. And though topic and thesis are not the same, if your initial move from subject to topic has been usefully informed and shaped by a survey of some of the relevant literature in your particular area of study, it should be that much easier to draft a viable working thesis from a statement of your topic when the time comes.

Question 2: Why am I writing?

What is your purpose? What are you trying to accomplish in writing about your topic? Are you trying to inform, explain, or describe? Are you trying to persuade or convince your reader of something? The last two questions speak to a general distinction in academic writing (with respect to purpose) between exposition and argument. To review some of the characteristics of these rhetorical modes, refer back to [chapter 1](#), noting that the modes of description and narration also discussed there are both considered subcategories of expository prose for the purposes of our discussion here.

As part of preparing to draft your document by first mapping out its particular rhetorical situation, it is important to try to anticipate some of the ways form and content may be influenced by purpose. A mainly expository document such as a lab report and a mainly argumentative one such as an article review or a persuasive scholarly essay will usually have quite a bit in common with each other in terms of formal components. Both, for instance, will exhibit elements of formatting and details of content that conform to a standard citation/documentation style (likely APA, which we will go over in some detail later in [chapter 8](#)). They will employ a title page, consistent double-spacing, and 12-point typeface. They will also include parenthetical citations throughout noting the use of outside sources and corresponding to alphabetized “References” page entries. Both types of documents will also proceed in a generally similar manner with respect to overall structure, beginning with some sort of introductory section that establishes with clarity the topic and approach, followed by a body section that discusses and engages with relevant research, then a summative conclusion.

In terms of the rhetorical strategies employed, however—in terms, that is, of the nature of the research-inflected content and how such content gets framed and presented throughout—exposition and argument can differ greatly. Consider, for example, the organizational schemes that structure the body sections. Much of a lab report’s body may follow a generally chronological scheme whose logic is dictated by a need to walk the reader through the ordered steps and results of an experiment. But the body of an article review is likely to be organized differently, in a way the writer deems most conducive to making whatever point it is she wants to make with respect to how or whether the article in question presents its research effectively. Because the primary concern of the review is with persuading a reader of something about the article being discussed—of making and defending some sort of evaluative assertion that at some level is rooted in the writer’s personal take—the writer’s own assessment of what points are most convincing and then of the most impactful and engaging way to order those points ultimately determines how the content gets organized. Frequently, writers will save what they deem their strongest, most compelling point for last. This subjective sort of author-determined, externally imposed scheme is sometimes referred to as **climactic organization**. Expository writing tends not to proceed climactically. Rather, it will usually employ some sort of internally imposed **exact organizational scheme** whereby content order is determined according to the more seemingly objective, linear logic of the material itself, whether chronological (as in documenting an

experiment's steps, per the lab report example) or hierarchical (as in that report's enumeration of the various methods employed or as in any sort of care plan or transfer of care document that describes and prioritizes what needs to be done for a patient, to take a non-academic example).

There are also some potential differences to anticipate between exposition and argument when it comes to diction and style. Certainly, it is the case that formal expository writing in health science fields (and science fields more generally) tends to shy away from the use of first person pronouns (*I* or *we*), wherever possible, so as to avoid sounding subjective. A document that means to persuade, however, will not be as invested in avoiding the first person, at least in part because, as noted above, to some degree an argument is necessarily always grounded in the writer's personal opinion, albeit a (hopefully) well-informed and convincingly presented one. In fact, arguments are often made more vigorous and forceful by way of statements that articulate and summarize the writer's position in direct, unambiguous ways (e.g., *I argue ...*, or *We suggest that ...*, or *My claim is ...*). Really, the use of the first person should not run counter to the overall project of trying to sound objective at all turns, so long as *I* and *we* are used sparingly and in ways that generally avoid unduly subjective, less forceful or assured-sounding constructions (such as *I think ...* or *We feel ...*). Contemporary science writing has come around to this fact (Hofmann, 2013).

Still, especially in the "Methods" portion of reports, wherein the materials used and the research or experimental techniques employed are described, passive voice constructions that obviate any need to employ first person pronouns continue to be standard (e.g., "Pancreatic beta cells were then transplanted into the diabetic patients, and the amount of insulin produced was monitored." Who transferred the cells? Who monitored the insulin production? It doesn't matter). See [chapter 6](#) to review the appropriate use of passive voice in healthcare writing. While it is not that such impersonal constructions don't have an important place in all types of academic writing, on the whole, in drafting something primarily expository, you need to be ready to write in a manner that keeps yourself out of things as much as possible. Such a consideration will not necessarily come into play when drafting an argument.

A Common Point of Confusion: Using the First Person in Academic Writing

Many writers have been told at some point in their formative academic lives—often by a well-intentioned high school teacher—not to use the first person when they write essays or reports. Certainly, there has been a long-standing resistance to using *I* or *we* in academic writing since (the thinking goes) the subject matter is what should always take precedence, and any sense of the experience or opinion of the writer who is addressing that subject matter might obscure, distract, or mislead. While the general attitude toward using the first person in academic writing has changed, older, outmoded aversions to the first person still exert influence. So when is it appropriate to use *I/we*?

As we discuss, argumentative prose of any sort is often improved with respect to clarity and directness of expression when the first person is used sparingly, emphatically, and in ways that avoid sounding like they signal personal reflections of the *I believe* or *We think* variety. Sometimes, using a first person construction can actually offer the most concise and direct way of saying something: *I propose ...* is definitely preferable to anything along the lines of the tortured, passive *It is proposed that...* In something more scientific in nature (like our recurrent example of a lab report), the first person will tend to be more appropriately employed in discussing the intellectual activity that impels the research being written up, as opposed to the actual labour involved in carrying that research out. To that end, *We propose ...* or *We discovered ...* are okay while *We added ...* or *We recalibrated* or *We cleaned ...* are not.

More generally, the impersonal *This essay argues* and the more personal *I argue* say pretty much the same thing. The former construction, however, tends to be employed more effectively by way of introduction, in a thesis statement or in the course of making some other contextualizing gesture. While the latter construction, *I argue*, can be used in a similar manner, it can also be employed quite usefully in the body of your essay as a sort of metacommentary prompt to remind your readers of what you want them to see is at stake overall, and perhaps of how to understand the cited work of others in relation to your own: “Author A has suggested ____; similarly, I argue that ...” or “Though researchers X and Y have indeed shown that ____, I am suggesting ____.” In the end, what you need to remember about the first person is that it is not at all wrong to use in academic writing, but it should not be overused since doing so risks eroding the overall appearance of objective distance from your subject matter that effective academic writers, particularly those in science-related disciplines like healthcare fields, should strive to cultivate.

Casting back to our discussion of Aristotle’s rhetorical triangle in [chapter 1](#), one way to think about the modes of exposition and argument with a view to mapping useful distinctions between them, especially at the very early prewriting stage we’re imagining here, is to consider the relative weight these modes put on each of the three interrelated rhetorical principles: ethos, pathos, and logos. Are all three things appealed to equally in all types of academic writing? The answer is no, though as we point out in [chapter 1](#), imagining the relationship between ethos, pathos, and logos as an equilateral triangle does speak usefully to the fact that effective writing needs always to strive for some sort of balance between all three. Each rhetorical principle should indeed register in every document, but not necessarily equally. If we can conceive of ethos in general terms as being author-centred, pathos as audience-centred, and logos as more content-centred, then we might anticipate that exposition will demonstrate an appeal to logos most strongly, with markedly less focus on either ethos or pathos. Argument, on the other hand, will appeal quite strongly to ethos and pathos, with perhaps a bit less commitment overall to logos.

Regardless of purpose, we need always to write academic documents in ways that generally strengthen our ethos by employing correct grammar and effective style and by using good research sources and treating them fairly. Still, we can correctly anticipate that any argument we write will tend to be a matter of self-presentation in more obvious and concerted ways, since it will necessarily derive from our own informed opinions on a subject and be framed from time to time by uses of the first person that an expository approach to our subject would mostly avoid. And while it is also the case that any effective piece of persuasive writing needs to make some strong enough appeal to logos by way of offering valid, reasonable claims throughout and supporting them by facts (often numerically expressed), the point to take here is that argument will invariably also incorporate attempts to appeal more directly to an audience’s beliefs, expectations, or emotions than exposition ever will. After all, the goal of academic argument is always in part at least to foreshorten the distance between a potentially antagonistic reader’s position on your topic and your own. Doing so necessarily puts more onus on thinking about what strategies for organizing and framing your research will work best for your imagined reader. This notion brings us to our next question, one that prompts us to do the important work (perhaps especially with respect to argument) of thinking about the composition and characteristics of our audience. Before moving on to that question, however, there are a couple of last things to note with respect to our discussion of purpose.

First, despite all our previous discussion of general differences between expository and argumentative writing, it is very important to remember that (almost) no academic document you will encounter is going to be fully one rhetorical mode or the other. In asking “Why am I writing?” your concern should be with anticipating distinctions in form and approach between documents that are mainly one mode or the other, or (what is more likely) between the often

extended and interdependent sections of exposition and argument that work in conjunction within a single document. A lab report, for example, will invariably conclude with a persuasive “Discussion” section, at least the first part of which will attempt to interpret the preceding experimental results and tell the reader what those seem to suggest and/or how those seem to answer one of the questions that prompted the experiment in the first place. In the discussion of her experiment’s results, a writer will organize and present an argument of sorts, showing more precisely how and why some of the key findings work to suggest what she says they do. Since in most instances experimental results may be interpreted in several ways, despite the primarily expository nature of a lab report, that document’s ultimate success depends in part upon how vigorously and authoritatively the writer can frame and support her position as to the significance of the findings at hand. It depends, that is, on how well the writer can move mid-document from explaining, enumerating, and describing to persuading. And in the case of an article review, though as we have noted the general goal is to convince a reader of the validity and merit of the writer’s position with respect to the given article’s rhetorical success (or lack thereof), no argument either way about what the article does or doesn’t do and why can ever hold water or even make sense without first being given appropriate context via some expository description (i.e., a summary) of the article at stake.

Finally, note that exposition is not merely the passive regurgitation of facts nor the unengaged and disinterested reporting of observations or experiences despite its more logos-heavy, decidedly less pathos- or ethos-oriented nature. Articulating and explaining something clearly and well—research methods and materials, say, or the main line of argument and nature of the supporting evidence in an article being reviewed—necessarily always involves constructing the reader’s experience of that material by making conscious, strategic decisions regarding framing and scope. What details should be included and excluded? What points should be focused on in detail at the expense of others? In short, how much and what of the overall experience or thing being described should the reader be able to access? In order to report on a subject, to explain it or to break it down into its constituent parts for analysis (perhaps as a precursor to engaging the details critically by way of something closer to an argument), these are the sorts of questions that determine your approach. In the end, no matter how concerted an expository writer tries to stick only to the facts and effect objective distance from her subject throughout, writing in a completely objective manner is simply not possible. A reader’s experience of anything we write—of the “facts” our document addresses—will necessarily be filtered through our own experience of our subject, shaped by and limited to what we have chosen to include and how we have chosen to include it.

Question 3: To whom am I writing?

Who is my audience? What, if anything, do I know about them? What sort of strategies will work best for my audience, considering what it is I want to accomplish (i.e., my purpose)? Perhaps more than anything else, awareness of audience influences the way you address your subject and follow through on your purpose. There are several different ways to draw distinctions between audience types—internal vs. external for work documents, for example—and one of the most common and broadly applicable is to identify your audience as either simple or multiple. A **simple audience** consists of like-minded readers with similar experiences whose knowledge of your subject, attitude toward it, and/or expectations regarding how a given academic document should proceed (with respect to format, organization, etc.) can be characterized with some confidence and without too much difficulty. The commonalities that unite members of a simple audience may be socioeconomic, cultural, educational, or professional. They may also derive from a shared purpose in reading. By contrast, a **multiple audience** consists of readers who come from differing cultural, educational, economic, or professional backgrounds. When it comes to a

multiple audiences, there is thus little uniformity of knowledge, experience, expectation, or attitude that a writer can anticipate with any certainty.

Increasingly in the professional world, many things healthcare practitioners write will be for a multiple audience: pathographies published online or medical blogs (both of which are discussed back in [chapter 4](#)) are just as likely in most instances to be read by other “expert” readers from the same educational/professional background as the writer as they are to be read by members of a “non-expert” public. The writer cannot then take for granted that all readers will be conversant in the same register and/or have access to the same terminology and frame of reference. To that end, to write in an effective and audience-aware manner, he will have to ensure among other things that important, potentially unfamiliar terminology gets clearly defined and that **jargon** is avoided entirely or kept to a bare minimum. He will also have to ensure that writing style (syntax, sentence lengths and types) maintains formality enough to be appropriately authoritative-sounding without coming off as overly stiff, academic, and off-putting to a general readership (in a way he would not were he writing only for a simple audience of fellow healthcare practitioners in the same field). The result can sometimes be a document containing a lot of static moments of exposition throughout that delay the forward movement of the overall argument, description, or narrative.

One nice thing about academic writing is that you can reasonably imagine the audience to be a simple one—your instructor and/or teaching assistant, sometimes other students in the class as well, particularly if there is a peer review or online posting component. In any case, because a relatively uniform and consistent knowledge base can be assumed, there will be less of a need to anticipate having to walk your readers through your subject in a basic way: fewer pauses for definition, explanation, and context; less of a need to eliminate specialized terminology in favour of more broadly accessible, non-expert language. Certainly, terms and concepts central to the course for which you are writing your report or essay don’t usually require definition or additional explanation, nor do ideas derived from assigned readings or lectures. Still, clarity and precision should always be top priority, so if there is any doubt about what your reader knows about your particular topic—even when that reader, like a professor, may be considered an expert in your general subject area—it makes sense to err on the side of caution by walking slowly and carefully through any important terms/ideas. At worst, you run the risk of exasperating your reader a bit by telling him some things he already knows. Doing so is always better than running the risk of losing that reader entirely due to a lack of sufficiently explained thinking at key points in your document.

Question 4: Are there any constraints or limitations on my writing?

What (if anything) might prevent me from addressing my topic and achieving my purpose to the best of my ability? Particularly since the majority of academic writing is done under some kind of time constraint—the spectre of an imposed due date—thinking about potential limitations as to how much or how well one can write with respect to a given document is an essential part of defining that document’s rhetorical situation. To recall the opening line of Andrew Marvell’s famous seventeenth-century poem “To His Coy Mistress” (c. 1650), “Had we but world enough, and time,” we would be able to research and write about our topic in as much depth and detail as it demanded, and at whatever length we required. Unfortunately, student writers must (like Marvell’s speaker) necessarily always “hear/ Time’s winged chariot hurrying near” (lines 21–22), since there is always a deadline looming and usually also the pressure of having other assignments to write as well. The upshot is that you will likely never write an academic document that isn’t limited in some way by circumstances either extrinsic in nature (such as due dates, limited availability of appropriate research sources, time constraints brought on by other school, work, or family commitments) or intrinsic to the assignment itself (assigned word limit, stated limitation on number or type of sources used). Effective academic writers plan around such

constraints. They do things like begin their preliminary research right away and/or select topics that might bear in some way on other things they are writing in order to maximize their research time and also allow themselves enough opportunity to switch gears if needed (perhaps as determined by source availability) by shifting, narrowing, or sometimes widening focus.

COMMON TYPES OF ACADEMIC WRITING

Moving on from thinking about the initial prewriting assessment process as it applies to academic writing, we now offer a brief rundown of some of the more common sorts of things students may have to write in the course of pursuing a degree or diploma in a healthcare field. Note of course that individual reader expectations may vary a bit from these general descriptions with respect to what each document should do and how it should look. When in doubt, remember that effective writers always do what they can to tailor their work to the needs of their particular audience. Be clear about what it is your reader wants and expects in any instance of academic writing, and always strive to give that reader what he requests.

Critical Analyses or Article Reviews

Article reviews engage with and provide a critical assessment of an assigned article from an academic journal, a newspaper or magazine, or an online source. The nature of the critique is to offer comment on the overall effectiveness of the article at stake, primarily in terms of two things: its contribution to knowledge in the relevant field of study and its rhetorical success in presenting ideas to the reader. Though “article review” and “critical analysis” are being used interchangeably here, an “article review” more specifically describes a particular genre of academic writing published in scholarly journals and concerned in main with examining contributions to knowledge. A “critical analysis” (or “critical response”) refers to the often more personally reflective versions of this genre that are commonly assigned in college and university courses. Just as they are in this discussion, fine distinctions between these two closely related types of similarly critically engaged and responsive writing tend to be collapsed by instructors, so in practice students may find either name (or both) being used to denote any assignment that requires reading, thinking about, and responding critically to an article.

As discussed above, article reviews are mostly persuasive in nature, though they will necessarily have to offer something in the way of a descriptive summary of the text being analyzed in order to frame your argument and provide sufficient context. With respect to audience analysis, assume your reader is passingly familiar with the article, a scenario that would likely be the case anyway if the article has been assigned by your instructor. Offer only as much by way of summary as you think you need in order to refresh that reader’s memory and/or to highlight the details of the article’s content that will be germane to whatever it is you are going to claim the article does (or doesn’t do) effectively. Your summary should set up your critical assessment by providing everything needed for that assessment to make sense. What is at stake in producing an effective summary of the sort required by an article analysis will be explored in more detail in the [next chapter](#). To anticipate that discussion, though, note that a summary of your article should certainly acknowledge the author’s thesis (i.e., the particular central claim she is trying to make and defend) and/or any identified problem(s) the author is trying to address. In the case of more scientifically inflected scholarly writing, your summary needs to acknowledge any guiding questions that impel the experiment or course of research being described. It should also include a concise overview of the article’s main points, the evidence it employs, and/or the solutions it proposes.

Depending on the length and complexity of the article in question, your summary may be just a sentence or two, or it may span a couple of paragraphs. In terms of structure and organization,

the summary logically precedes your actual critical analysis. The most common scheme for ordering article reviews has the summary portion second, following an introduction that names the article specifically (by author and title, plus venue of publication or, if required, full bibliographical reference), gives some relevant details about the article's rhetorical situation (e.g., Who does the intended audience seem to be? What is the author's purpose?), and states concisely the article's topic and thesis or main point. The introduction must also state your own thesis concerning the article's overall success or lack thereof (per the example of a critical analysis essay below).

After the summary section comes the central, most extended portion of the review. In the body, you engage with details of language, content, and/or argumentative logic to evaluate the relative strengths and weaknesses of the article with a view to supporting your assertion about how/why the article works to achieve its purpose (or doesn't), or how/why it successfully contributes and conveys useful knowledge (or doesn't). Obviously, any point you make about the article in the course of analyzing it and offering your evaluative commentary needs to be anchored in concrete, representative examples. If you suggest, for instance, that the support for a particular point the author wants to make is insufficient or problematic, show the reader in detail precisely how what you say is the case. Likewise, if you are arguing for a disconnect between what the article seems to intend to do (per its stated purpose and/or guiding research questions) and what it actually ends up accomplishing, walk the reader in detail through relevant lapses in logic and coherence by addressing and exploring in detail some specific, telling examples.

And particularly if you are trying to suggest something about the author's use of language or her writing style, you absolutely must take recourse to representative quotations to prove your point. Telling must always be accompanied by showing in a critical analysis. The upshot of such an onus on providing and discussing details is that any argument you want to make concerning the article in question has to be a tightly focused one. It will simply not be possible to demonstrate to your reader everything you know about how and why the text succeeds or falls short of the mark, nor should that be your goal. Rather, you should strive always to demonstrate depth and precision of critical engagement and analysis instead of breadth of knowledge. Keep the parameters of your analysis relatively narrow. The point of doing so is to give yourself enough time and space to build a convincing, sufficiently detail-focused case for the validity of your take on the article in question.

Example: Student Critical Analysis of "When it comes to waiting for health care, Canada is last in line" (2013, February 19). *Maclean's*.

[<http://www.macleans.ca/politics/when-it-comes-to-waiting-canada-is-last-in-line-2/>]

the introduction by clearly identifying the article title, date, and publication venue. Note that there is no author name provided, so this student opts to use either "the article" or the title throughout, though "the author" would be acceptable. Within the first couple of contextualizing sentences here, the rhetorical situation of the article being analyzed also gets identified: audience ("concerned Canadians"), topic (the problem of wait times), and purpose (to inform and to persuade by urging action).

Introduction establishes the parameters of the essay's evaluative commentary. The thesis statement focuses on one particular shortcoming of the article and identifies how and why that shortcoming is significant. The narrow scope of the analysis as defined here is suited to the relative brevity of this essay overall, as determined by a 1000-word limit.

Second paragraph situates the article contextually as part of an ongoing "urgent debate," then it offers a concise summary of the article's main points.

The February 19, 2013 *Maclean's* article "When it comes to waiting for health care, Canada is last in line" reveals to concerned Canadians that compared to citizens of all other developed countries, they wait the longest and most often for healthcare. The article insists that although improvements have been made over the past decade to shorten wait times, the situation is still far from satisfactory; thus a "real and permanent solution" to the problem is in order. However, despite providing statistically based evidence sufficient enough to justify and reinforce the claim that current wait times leave much to be desired, the article notably fails to offer any comment on the quality of care patients receive after their waits. Such information on wait times in conjunction with care quality would aid readers in developing a more impartial and correctly informed opinion of healthcare in Canada, and without it the article is not able to present as full and fair a picture as it should of the wait time issue.

The article adds another voice to what has become an increasingly urgent debate by insisting that lengthy wait times for medical attention in Canada are indeed a significant flaw in what many view an otherwise solid, even enviable healthcare system. Cited evidence on wait times, primarily from the Organisation for Economic Co-operation and Development (OECD), reveals the urgency of the wait time issue in Canada. The research provided in the article also shows that Canada's comparatively large investment in healthcare has not translated to faster service standards. Although initially exhibiting a wholly negative position with respect to the wait time issue, the article goes on to acknowledge how effort has indeed been expended in order to reduce wait times. These measures include prioritizing wait times and enforcing the online posting of benchmark wait times provincially. Somewhat ironically though (the article suggests), improvements experienced due to these new initiatives have only further reasserted the severity of the problem, as Canada's wait times continue to disappoint. The article ultimately urges Canada to avert its focus from trying to avoid unduly high healthcare expenditure to trying harder to lead the way in healthcare innovation around the world by seeking a lasting solution to the wait time crisis.

Reinforced throughout by way of continued recourse to quoted research from a reputable source like the OECD, this article makes it plain to see for the reader that extended wait times are a very serious flaw in Canada's healthcare system, and it urges the reader that Canadians "can do better." Yet as convincing as its logos-heavy strategy is on the whole, "When it comes to waiting for health care, Canada is last in line" sustains an approach to its topic that is too one-sided to be as effective as it might. As the article rightly acknowledges, Canada's healthcare system has long been a point of pride and cultural identity for Canadians, and logic would dictate that the system has not earned

its stellar reputation globally for nothing. The quality of Canadian healthcare continues to be very good indeed. Yet the article fails to discuss the important issue of how wait times may coincide with patient care quality. Quality of care should be central to any conversation about the relative merits of healthcare systems, and given the article's seeming position of concern and advocacy for its Canadian readers who are being let down by their failing system, it is surprising this topic was not addressed in some way. In a non-urgent situation, most individuals would likely be satisfied if their patience was met with first-rate care; that experience would presumably make the admittedly long wait more worthwhile and perhaps more understandable. Certainly, providing some consideration of how high quality care is often the end result of having to wait would put into better, clearer perspective the article's rather manipulative use of alarmist language to set a negative tone at the outset in provocatively claiming that "sometimes [waiting] can be life-threatening." While, as previously noted, the article provides a lot of resonant statistics throughout on things like how often Canadians seek emergency hospital care in comparison to other developed countries and how long they usually end up having to wait for it—over four hours, on average—it would have been beneficial for the article to complement such research with some information about, for example, Canadians' overall satisfaction with their care quality in order to offset the negative portrayal and allow the readers who the article assumes see little value in waiting for medical care to draw their own opinion on that topic from a more unbiased, even-handed, and well-informed take on their care system.

Unquestionably, "When it comes to waiting for health care, Canada is last in line" provides convincing evidence to illustrate the fact that Canada's healthcare wait times are comparatively substandard. The article, however, fails to come off as convincingly as it might since it does not attempt a fair and full review of our healthcare system, but instead focuses all of its rhetorical energy on reasserting just a single, highly publicized negative issue. Although the evidence presented is compelling and difficult to dispute, it seems unfair—not to mention problematically reductive—for our healthcare system as a whole to be characterized by this one negative aspect. With fairness in mind to the Canadian readers for whom the article claims to advocate, some exposure to one of the recognized benefits of longer wait times—high quality care—would have enabled readers (and potential patients) who are perhaps questioning the quality of Canada's healthcare system to arrive at their own more fairly and broadly informed opinion of the system as a whole, positive or negative. In some ways, this article and the fundamentally flawed healthcare system it aims to describe are alike: both end up letting us down by failing to provide everything we require and deserve. Maclean's readers, like the Canadians who continue to wait too long for their healthcare, can indeed do better.

Central portion of the analysis develops the thesis statement regarding what the article fails to do by way of specific references to and quotations from the text.

The instructions for this particular assignment asked students not to do additional research to bolster their evaluative claims. The overall result is a more reflective, opinion-based response. This particular point about the sort of information that might have been provided could certainly be usefully enhanced by way of an example drawn from research, however.

Conclusion reiterates and summarizes the central argument about the article. But importantly, it does so in language that doesn't just rotely restate how that argument has been expressed elsewhere in the essay.

Analysis closes with a thought-provoking statement that recalls the language of the article to make one final reassertion of the writer's main point about how the article falls short.

Being a Critical Reader

Sometimes when article reviews are assigned, a set of guiding questions will be provided to help you situate your article in relation to relevant course concepts and to shape your response in a particular way. Whether such structuring questions are given or not, however, there are some common strategies for reading an article in an active, critically productive way. Returning to the notion of **critical reading** that we introduced in **chapter 3**, to be a critical reader in the context of academic writing is to study carefully an article under analysis—or any kind of text, really—with a view to understanding just how it is working to explain or to persuade (or both). What

strategies are involved? How do those strategies manifest themselves in terms of language, organization, and/or the scope and sort of evidence provided? Why are those strategies effective? Why aren't they?

Critical reading is distinct from **ordinary reading** (sometimes referred to as previewing), which refers to the sort of "doctor's office waiting room" experience of reading an article from start to finish, in an uninterrupted, often cursory manner that engages primarily the explicit, most immediate concerns of content (author, subject matter, author's seeming purpose) and context (e.g., venue of publication, your initial interest level, whether you agree/disagree with the article). Previewing provides a necessary first interaction with an article. An effective analysis, however, can only be the product of employing good, active (which is to say, critical) reading strategies that aim to move beyond just the explicit, obvious things and address important considerations that are more implicit and subtle in nature. Critical reading should be goal-oriented: its aim is to provide you with a much deeper, more nuanced and sophisticated understanding of what informs and shapes the article at hand. The act of ordinary reading is relatively quick and linear. Critical reading, on the other hand, is characterized by a much slower pace and frequent pauses to think, take notes, and go back over something. Invariably, you will need to reread the article several times to get a sufficiently well-developed picture of it and to become as conversant as you need to be with its details.

Though you need not ask all of these in every instance, nor will all of them yield useful answers, some of the basic questions you can pose as means of focusing your critical reading efforts are as follows: What are the author's credentials? What does she do to appeal to ethos (credibility, authority, likability)? When was the article published? Who is the intended or imagined audience? What would that audience think, feel, or know about the topic? Does the article seem to keep the interests or expectations of its audience in mind? Recalling the focus of the sample analysis above, is there anything seemingly important that is conspicuously absent from the article? If so, what might account for that omission? Is there perhaps some sort of personal bias or professional agenda motivating the author?

Casting outwards a bit more, you might also want to think about some considerations of broader context. What is the cultural, political, and/or historical situation of the article? Does it seem to be participating in any larger social or political or academic conversations that might be informing how it addresses its topic? In our sample analysis essay, the student writer begins the second paragraph with an acknowledgement of how the *Maclean's* article she is analyzing reiterates an established position within a recognizable, ongoing national conversation about wait times. Note that in the case of a scholarly journal article, there will almost always be an ongoing conversation to which the author's research contributes. Frequently, journal articles will even make explicit reference (in the body of the article or by way of a source citation) to something previously published to which the author may be offering some sort of response, whether a development or a departure. Keep in mind that academic writing is always characterized to some degree by intertextuality. Being an effective critical reader of such writing will require you to be diligent about trying to familiarize yourself with relevant intertexts in order to gain a fuller understanding of whether or not a journal article's approach to its topic is a valid or useful or problematic one.

Strategies for Critical Reading: Questions and Tasks

READING STAGE	QUESTIONS	TASKS
Initial (previewing/ordinary reading)	Basic questions of explicit content/immediate context	

	Who is writing? What is the publication venue? What is the title? What is the topic? What is the purpose? What is the argument or main point (generally)?	Identify any terminology or concepts with which you are unfamiliar. Note any sections that seem unclear, illogical, or are difficult to understand.
Subsequent (active/critical reading)	Questions of structure, focused questions of content What is the article's thesis, specifically? What evidence is used to support that thesis and/or to explain the topic? How is the content organized? What is the logical structure or movement of ideas? Are there any logical inconsistencies or issues of overall coherence? Does the writer acknowledge opposing ideas or points of view? If so, does she do so fairly and effectively?	Stop to look up definitions for terms that are still unfamiliar; seek clarification of concepts that are still unclear. Paraphrase the thesis statement or problem(s) being addressed or guiding research questions. Summarize the article.
	Questions of personal response Am I persuaded by or satisfied with the article's content? Does the research used actually support the thesis and/or lead to the stated conclusion (and thus help to solve the identified problem)? Are there any notable omissions or oversights in the research? Am I familiar with any other things written on the same topic that might be usefully put into conversation with this article? Do I think the style and language are appropriate and effective? Why/why not?	Mark specific points of content—details from research provided, examples of language—that you find particularly effective or troubling. These will begin to help you establish the evidentiary basis of your analysis and evaluation.

One thing more with respect to the mechanics of writing effectively about articles: even though a critical analysis necessarily requires you to engage with something written in the past (whether recent or less so), be sure to employ present tense verbs when discussing the article. The sample analysis here refers to how the article “adds ... fails ... provides” (etc.), not how it “added ... failed ... provided.” Think of a published document as something not of the past but of the present—something that continues to exist each time it is read. If you refer to an important detail about something the author or someone the author references has done in the past, however, use the simple past tense, assuming you are describing a role or action that is not ongoing. Consider the difference between “Jones surveyed over 500 undergraduate nursing students ...” (which makes reference to a completed past action in describing the methodology of a particular research study) and “Jones has studied grade trends in nursing programs for several years ...” (which refers to an ongoing course of study begun in the past, by way of providing context). The former example employs the simple past tense, while the latter employs the present perfect; the present perfect progressive tense (i.e., “Jones has been studying ...”) would also be acceptable in the second instance. Refer back to the discussion of verbs in [chapter 6](#) for examples of these tense forms.

Reports are primarily expository, research-based documents. Often experiment-focused in nature, their purpose is to present and analyze research findings, either the writer's own or those of others. Reports differ from article reviews or critical analysis essays—from essays generally—in several notable ways. For one, since its purpose is to argue for the relative rhetorical or intellectual successes or shortcomings of a given article, a critical analysis is necessarily more informed by the opinion of the writer, its content more obviously filtered through and shaped by the writer's own experience of and approach to the subject matter (namely, the text being analyzed). In a professional setting, persuasive reports may be written to recommend some course of action that should be undertaken in order to eliminate an identified problem. In an academic setting, however, it is usually the case that a report aims to inform—to convey factual information in an objective way, without necessarily trying to get the reader to do, think, or agree with anything. If academic reports veer away from the expository mode and toward argument at all, it will be perhaps, as we have previously noted, in discussing the significance of the research or experimental findings presented and in interpreting them for the reader.

Another key way in which a report differs notably from an essay is in terms of structure and format. All academic writing is necessarily formal. Both reports and essays will employ tone—a function of diction and style—that is appropriate to their research-based subject matter and indicative of their general nature as academic documents. Reports, however, often seem more rigidly formal in appearance because they tend to conform to a particular set of expectations regarding format and organization that do not (usually) apply to essays. For example, reports of all lengths frequently employ headings throughout the text to separate large conceptual sections and to introduce/anticipate the nature of the information in the section that comes next and/or the function of that section.

Sometimes, research essays that are much longer than what is usually expected of critical analyses (which tend to be reasonably brief: 800–1000 words commonly) will employ report-style headings to signpost the progression of their argument, particularly in moving from one very long section of discussion or analysis to another. On the whole, though, essays tend to eschew such mechanical ways of mapping the organization and movement of ideas in favour of emphasizing a greater sense of cohesion and the close logical and conceptual connection between paragraphs through the use of transitional expressions (i.e., logical markers) that signal shifts, progression, development, or relation. As well, essay writers will sometimes announce shifts in focus or departures from/returns to the main line of argument by beginning certain paragraphs with metacommentary statements that bring the reader up to speed, summarizing what has come before and anticipating what will now be addressed (e.g., “I have been arguing up to this point that ... I now want to suggest ...”). The key point to take here is that the mainly expository nature of reports gets enhanced by the use of headings that break up the information being discussed into coherent, manageable, ordered chunks. The argumentative nature of an essay, though—as well as the climactic organizational scheme most conducive to that nature—is much better served by maintaining and enhancing the appearance of tight logical relationships between sections/paragraphs and by facilitating a more seamless flow of ideas.

Academic reports also conventionally demand the inclusion of components that essays frequently do not have:

- abstracts (which are a particular sort of summary that we describe in the [next chapter](#))
- sometimes a table of contents and/or a list of figures and tables
- often a distinct literature review section that helps to frame and establish the place of the research being discussed within the ongoing scholarly conversation
- an enumeration of methods and materials (in the case of lab reports)
- appendices containing important material that supplements or explains points of content but would negatively affect coherence or length were it included in the report body (e.g.,

raw experimental data referred to and interpreted in the report, descriptions of equipment used in experiments, graphs/tables/calculations referred to in the body, etc.).

Scientific reports in particular will conform to a fairly standard set of formal expectations with respect to content and organization. These can be remembered with the acronym IMRaD, which signals the four distinct sections a lab report needs to contain: Introduction, Materials (and Methods), Results, and Discussion. This last section is sometimes called Conclusions—or at least it is sometimes inclusive of a separately labelled Conclusions section—though IMRaC or IMRaD/C just don't have quite the same ring to them.

Not all reports follow this IMRaD model, however, since it is best suited to articulating experimental results. Let's take the example of a report on the use of embryonic stem cell therapy as a potential cure for type-1 diabetes that is based not on the writer's own course of research or experimentation but instead, as will commonly be the case for university and college report writers, on reviewing and analyzing the existing published research (both primary and secondary) on the subject. After the standard fare of title page and abstract, your report will open with an introductory section that states the topic at hand, identifies the scope of the analysis and, most importantly, provides a clear and unambiguous **statement of purpose**. To look ahead to the discussion of essays below, this statement is effectively the thesis of your report, and it should similarly anticipate the nature and focus of the research that you will marshal in the body portion.

Strategies for Drafting an IMRaD Report: Questions of Purpose and Content

REPORT		
COMPONENT/HEADING	QUESTIONS OF PURPOSE	QUESTIONS OF CONTENT
Introduction	What is my guiding research question? What is my hypothesis (i.e., the idea or assumption that is the basis of your investigation here, the thing you are trying to prove)?	How did I arrive at my research question? How did I come up with my hypothesis? What published research am I responding to and/or in what ongoing scholarly conversation/debate am I trying to participate?
Methods (and Materials)	What is my experimental approach or research methodology? In what manner do I proceed? What sort of materials do I use?	How am I testing my hypothesis and/or responding to my research questions? Why am I proceeding in this way?
Results	What is the nature of the data I am collecting?	How is my data being evaluated/analyzed? Can I present that data in some sort of visual format that might make it more accessible or engaging (e.g., chart, table, graph)?

Discussion (Conclusions)	Do my experimental/research results actually seem to support my hypothesis and/or answer my guiding research questions?	How should I interpret and explain the results for my reader with a view to demonstrating their support for my hypothesis? What might be the next step or direction for this course of research? What other experiments might be done to yield results that similarly support or further advance my hypothesis? What (if anything) are the limitations in experimental design or research methodology that I will need to acknowledge to seem authoritative and objective (e.g., to cultivate ethos effectively)?
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(Adapted from Hofmann [2013], p. 90)

Note that a report introduction along these lines will commonly follow a general-to-specific pattern, beginning with a broad statement—though never any broader than the scope of your topic, which here is limited to diabetes and/or embryonic stem cells—and moving in the span of perhaps four or five sentences (in a short report at least) to a more specific, decidedly narrower take that culminates in a defined statement of purpose. For example:

Opening sentence begins broadly, but not too broadly, speaking to diabetes generally and allowing for a move in the second sentence to a slightly narrower statement of the report's scope and an announcement of its topic. Note too that the student writer opens with some salient, striking data drawn from secondary research as a way of immediately engaging the reader. She also cites that research parenthetically, using APA style.

Diabetes mellitus is a chronic disease that affects approximately 346 million people worldwide (World Health Organization, 2014). There are multiple types of diabetes, but the focus of this report will be type-1, or insulin-dependent diabetes. Type-1 diabetes is most often caused by an autoimmune attack by the body in

which the insulin-producing cells of the pancreas, called beta cells, are destroyed. The destruction of these cells creates an insulin deficiency that results in high blood glucose levels, and these high glucose levels in turn damage blood vessels and consequently lead to serious medical complications. Because of their insulin deficiency, type-1 diabetics must receive synthetic insulin through subcutaneous injection or pump (Franz, 2008). Although synthetic insulin is certainly beneficial, it is not equivalent to that which is naturally secreted by the pancreas. Normal functioning beta cells produce the exact amount of insulin necessary to balance the blood glucose levels; however, synthetic insulin is administered by the patient him- or herself and, therefore, will never be as accurate in dosage (Slack, 2014). To date, there is no cure for type-1 diabetes. As this report explores, however, there have been several advancements in the field of embryonic stem cells including recent groundbreaking research from the Harvard Stem Cell Institute that may promise a cure in the near future.

Type-1 diabetes is explained in sufficient detail up front so the writer can take for granted going forward in the report that her reader understands this important term correctly.

The writer employs the impersonal "this report" instead of using the first person, keeping with the need to sound as objective as possible in reports.

"Embryonic stem cells" is another important term going forward, and it warrants further definition in the body of the report.

The statement of purpose articulates clearly and concisely what the rest of the report will go on to do, namely discuss—the writer says "explore"—advancements in stem cell therapy as they apply to type-1 diabetes, with a particular focus on the Harvard Stem Cell Institute.

Moving on from the introduction, the first portion of your report's body may consist of a literature review that collects and summarizes (in brief) some of the important research articles you have found regarding the use of stem cells to fight type-1 diabetes. While expansive, article-length literature reviews that survey the contemporary and historical research on a given topic are a conventional and important type of scholarly writing in various academic disciplines (including the health sciences), the sort of literature review you are usually required to provide in the context of a research report is far less comprehensive and much more condensed and manageable. You need only include the sources most relevant to whatever it is you are trying to discuss or explore. In the example here, the literature review would be limited to sources that document the stem cell research referred to in the statement of purpose, even though (presumably) you would have had to read much more widely in the course of making that all-important move from general subject to specific topic at some point during the prewriting stage. In any case, regardless of scope or length, all literature reviews serve the same rhetorical purpose of building your ethos as a writer by showing you to be well read on your topic and, thus, authoritative.

The rest of your report body would then be devoted to discussing in greater detail the "several advancements in the field of embryonic stem cells" to which the statement of purpose refers. Since the order of your discussion needs to be consistent with any sense of order the statement of purpose might anticipate, it is reasonable to assume that a number of examples of important, ongoing work on stem cell therapy will be provided, leading up to a perhaps longer and more sustained description of the Harvard Stem Cell Institute research. It is also likely that you would employ conceptual headings throughout to separate and introduce the various versions of stem cell research you discuss. The important thing to note is that while stem cell therapies may be compared or contrasted in the body of the report, no argument will be made regarding the relative effectiveness of one over the other. Again, the point is to be strictly informative. Tell the reader about each type of therapy by employing the research you have collected, but don't

interpret that research in any way that requires you to make an assertion about it that you will then have to defend, and/or that is in any way informed by personal opinion (e.g., as to which sort of therapy is better/worse or more/less effective). Stick to the facts and try to effect the appearance of objective distance throughout.

As far as your conclusion goes, unlike an experiment-based lab report, which will conclude in part by looking ahead to the next step for continuing a course of research in the topic area, a report based on compiling research from secondary sources will conclude in a primarily reiterative manner, restating the objective of the report (though doing so in different terms) and revisiting the key points of content by summarizing them. It is often useful to reserve an interesting statistic or resonant quotation for your conclusion, in the same way that the sample opening paragraph above begins with something provocative to garner interest. That said, be sure not to introduce any new research in your conclusion, since you don't want to leave your reader expecting you to develop or elaborate on some point of content when there is no further opportunity to do so. Here is an example of a possible summative conclusion:

In one sentence, the writer summarizes the content and organization of the report, which (presumably) moves from discussing the various versions of stem cell research that pre-date and lead to the Harvard team's.

This is a version in this report of the sort of forward-looking gesture that an experiment-based report might make regarding the positive potential for further research.

The writer references here a point of focus in the body discussion of the Harvard research. Note too that the language in this paragraph recalls but doesn't reproduce the language used in the introduction to frame the topic and state the purpose.

After several years of stem cell research focused on improving the lives of diabetics, a new method for preparing embryonic stem cells has finally been able to produce adequately functioning beta cells for transplantation. If this study successfully continues through the clinical trials, millions of type-1 diabetics worldwide may be able to stop their insulin injections and live normal, healthy lives. The Harvard research team that developed this procedure has been able to foresee future complications and has consequently been trying to develop solutions to these issues before they arise. A cure for type-1 diabetes could be within reach in the next few years, resulting in many changed lives and many prevented deaths.

The final line seems to return things full circle to the introduction by responding to the statement there that "To date, there is no cure for type-1 diabetes." Everything in this passage is summative.

Scholarly Essays

As we point out earlier in this chapter using the particular example of a critical response, the essay differs generally from the report with respect to both purpose and format. In terms of its etymology (or word origin), *essay* comes from the French verb *essayer*: to try or to attempt. The Old French variant of that verb, *assay*, refers to an examination. Both meanings seem usefully to inform our contemporary understanding of just what an essay is supposed to do; it is at once a close examination of your subject and an attempt to say something about it. In saying something about your subject, you are making an assertion. You are stating an arguable claim that then must be supported in the body of your essay by way of research. And indeed, it is the expectation that research will be employed in the task of defending an assertion that distinguishes the scholarly essay from other types of essays that students in healthcare programs may be asked to write (such as personal reflection papers, which may or may not be argumentative in nature; or critical analyses, though these can include research in some instances). The articulation of

whatever assertion it is that you are making—your central claim—comes in the form of a clear and concise **thesis statement** that, like the statement of purpose in a report, establishes the particular focus of your document and anticipates the nature (and sometimes the order) of the material to follow. Like the statement of purpose, at least in relatively short essays, the thesis statement will tend to be the concluding point in an introductory paragraph that follows a general-to-specific progression (see the example on p. 168).

Good thesis statements will always be defined by two important characteristics: they will be **specific**, and they will be **significant**. Specificity refers to how precisely the parameters and focus of your argument get defined in your thesis. Significance refers to whether or not your thesis gives you something to do or prove in the body of your paper. Imagine that you have been tasked with writing a scholarly essay that explores a problem associated with the current Canadian healthcare system. How would you move from the assigned subject to a working thesis? As noted in our discussion of the prewriting stage, stating your topic usefully requires first narrowing the focus of your subject. A thesis statement constitutes an even narrower, more specific take on your topic.

Subject (broad): problems with Canadian healthcare.



Topic (narrower, arrived at after some preliminary research): Canada's one-tier healthcare system as the cause of excessive wait times.

Now that you have arrived at a topic at least tentatively, further, more focused preliminary research can enable you to cast that topic as a series of research questions whose answers will help you make an assertion about the topic and lead you closer to a functional thesis statement. For example, after coming across various sources concerned with whether or not Canada actually has the one-tier system it claims, whether the logistics of a one-tier system cause more harm than good, and whether or not a move to a two-tier system akin to the sort other countries use would be beneficial, you might then ask the following:

“Could introducing a two-tier system help alleviate the particular problem of wait times? How so? Are there additional benefits to implementing such a system?”



Possible thesis statement in response (focused assertion about topic): “The introduction of a true two-tier healthcare system in Canada would not only alleviate the long wait times associated with the current one-tier system, but it would also benefit Canadians by providing them additional options to obtain the care they require while still preserving the principle of universal healthcare.”

In terms of specificity, this thesis statement does well to identify a particular problem, associate that problem with a particular characteristic of the Canadian healthcare system, and make a claim regarding how the identified problem might be solved by altering the system in a particular way. In terms of significance, the second essential characteristic, this thesis also seems to hit the mark in so far as it doesn't say something that is obvious or inarguable. While many people might agree with your stated position—after all, that position comes about as a result of your familiarizing yourself with what others have had to say on this topic—not everyone will, and that is the point. Especially at the university undergraduate and college level, the significance of a thesis statement is not contingent upon making a claim that breaks new intellectual ground or says something that no one else has said. Rather, your thesis statement need only articulate some

sort of position for which you can build a (hopefully convincing) case by presenting and interpreting research from relevant sources. If you can't or don't need to marshal any research to support the claim your thesis articulates, then it is not a claim worth making in a scholarly essay, or perhaps not a claim at all.

One other thing the sample thesis statement here does usefully is to give the reader some general sense of how the ensuing essay will be organized. It seems to suggest that the first order of business will be to show how a two-tier system can work to solve the wait time issue, after which the essay will go on to spend some time demonstrating two salient additional benefits of such a system: better selection of care options, and preservation of the important principle of universal care. This anticipatory quality is referred to as **signposting** (or forecasting), and it is an important third characteristic of an effective thesis statement, though it is not necessarily one that all thesis statements will demonstrate. Generally, it is the case that the longer an essay is—and note that length is often commensurate with complexity of topic—the more difficult it will be for a thesis statement to signpost the organization of ideas in an essay in an adequate way. For a shorter essay, however, there is usually little reason that your thesis statement can't make some attempt to provide the reader with a general sense of how your main points will be ordered. And remember that you must ensure that the organization of your essay's body corresponds with any indications your thesis may provide with respect to order. In our example here, for instance, you couldn't begin your discussion by showing how a two-tier system still allows us to adhere to the principle of universal care, as that particular point should be discussed last, according to the thesis.

Recalling what we said earlier on in this chapter about the general differences between the sorts of organizational schemes that tend to be employed in the cause of exposition and those that are used in argument, how you go on to organize the main points of your scholarly essay is largely up to you as a function of how you think your case unfolds most convincingly. Note, though, that an essay writer's job is not actually to convince the reader of his position, rather to demonstrate that his position is a viable, well-supported one. You need not feel that you are on the hook to win over to your position the hearts and minds of antagonistic readers, only to demonstrate to those readers that you have done a good job in showing that your central claim has merit. And note as well that just because your essay body is likely to employ climactic organization overall, that doesn't mean it can't employ other (e.g., exact) schemes at specific times throughout, when the nature of the content is such that, say, a chronological arrangement might make the most sense (as in the case of walking your reader through the history of Canada's current healthcare system by way of setting up your argument in favour of adopting a two-tier model).

A Common Point of Confusion: How Do I Deal with Opposing Viewpoints in My Argument?

In the course of putting together research sources to support your central claim, you are likely to encounter some that articulate positions or offer ideas that run counter to the claim you are trying to make. After all, for that claim to be arguable in the first place, it has to be disputable. Like any piece of academic writing, a scholarly essay necessarily locates itself within and contributes to some sort of ongoing conversation, and there are always multiple perspectives informing those conversations. As a writer of argument who should be focused on making the strongest, most well-supported case possible in developing and defending your thesis, you may first be inclined to ignore strong opposing voices. The better strategy, however, is always to invite such contrasting or contradictory research into your work and to find a way to engage it without undermining the quality or effectiveness of your argument. In terms of cultivating ethos as someone whose words are worth reading and whose ideas are worth entertaining, you

never want to come off as closed-minded, and you always want to show respect for your readers. That is, you want to show them that you are fully aware that they know yours is far from the only voice that has addressed the topic at hand. Doing so will only serve to make you seem more trustworthy, reliable, authoritative, and confident.

Also, as Graff and Birkenstein (2010) point out in *They Say, I Say*, their excellent little book on the strategies used in writing academic argument, “the more you give voice to your critics’ objections, the more you tend to disarm those critics, especially if you go on to answer their objections in convincing ways” (p. 79). Always imagine that you are writing your essay for an at least mildly antagonistic reader. It helps you to anticipate potential points of weakness or possible objection—referred to as **conditions of rebuttal**—as you start building your argument. If someone is looking to undermine your position, how could he best go about doing that? Take all potential objections seriously, and devote sufficient space in the course of your argument to dealing with the most pressing. When you are writing to a word limit, dealing effectively with “naysayers” (to employ Graff and Birkenstein’s term) often entails having to excise some part of your discussion that might have been otherwise useful. And while not all possible points of objection you anticipate will warrant being addressed in your essay, those that do need to be responded to in a persuasive way.

There are two primary strategies writers can employ in the task of dealing with opposing points of view: **refutation** and **counterargument**. The first requires you to seize upon some shortcoming(s) inherent in the objection you are addressing, or in how that objection gets presented in a particular research article. To refute a position effectively, you must be an adept critical reader. In a counterargument, on the other hand, you acknowledge the strength and validity of the objection, but you then re-assert the strengths of your own position—or perhaps of the particular point to which the objection at issue responds—to show how your argument still stands and how it demands consideration even alongside strong opposition.

In the end, be sure that there is nothing in the body of your essay that isn’t a necessary component of your argument, and aim in constructing the body portion to lend a greater sense of coherence and logical progression by employing appropriate transitional expressions within and between paragraph sections where necessary. Do not overuse such logical markers, however. A clear, well-written topic sentence at the outset of a paragraph can serve just as effectively to orient your reader to what is at stake in the section of discussion that follows and, presumably, to how that point fits into your argument as a whole. Also, try to avoid needlessly mechanical transitions such as “First, ... Second, ... Third, ...” and/or (what’s worse) “In conclusion.... ” While in theory there’s nothing incorrect or untoward about wanting to signal that your essay is about to draw to a close, “In conclusion ...” is overdone and usually redundant, since (per the sample essay below) the onset of your conclusion should be apparent to your reader already by virtue of some sort of summary statement at or near the beginning, not to mention the fact that in a short essay your conclusion will be relegated to your final paragraph.

Example: Student Scholarly Essay—“The Need for a Two-Tier Healthcare System in Canada”

Like the report example above, this essay's introduction follows a general-to-specific pattern. The opening statement makes a broad gesture, but keeps to the general parameters of the topic, Canadian healthcare.

The thesis completes the general-to-specific scheme, defining with precision and sufficient detail the focus of the discussion to follow and making a strong assertion that requires support in the form of research evidence.

Topic sentence here signals to the reader that this paragraph provides historical context. It is a gesture common enough in academic essay writing to take a step back after your thesis statement and provide the necessary context for your argument before actually launching into the argument itself.

The writer employs APA citation style throughout. The accompanying "References" list has a full bibliographic entry corresponding to each parenthetical source reference.

The topic sentence here anticipates the paragraph's focus on the problem of wait times.

Canada has long prided itself on a key feature of its identity: universal healthcare for every Canadian resident. The main goal of Canada's healthcare system is to ensure that universal coverage is available and accessible to all Canadians, regardless of their ability to pay. Although this system provides Canadians with the comfort and safety of having free healthcare when medical necessity arises, it does not exist without flaws. Over 70 per cent of Canadian healthcare funding comes from taxation; therefore, there is a great deal of financial pressure on the public system (Johnson & Stuart, 2009). The biggest issue that has arisen from this pressure is an increase in wait times. Canadians are forced to endure long wait times for medically necessary procedures, and they are often forced to seek sometimes dangerous alternative means of accessing the care they require. Implementing a two-tier healthcare system has been highlighted by many as a possible way to counteract the negative side effects of Canada's one-tier system, such as long wait times, and it is a suggestion with considerable merit (Flood & Haugan, 2010). The introduction of a two-tier healthcare system in Canada would not only alleviate both the financial stress on the current public system and the increasingly long wait times for care, but it would also allow Canadians to have additional options to obtain the care they require while still preserving the principle of universal healthcare.

Canada's healthcare system has evolved over the past six decades to eventually form into its current model. Throughout this evolution, there have been several monumental social movements that have contributed to the system's formation. This rich history of social responsibility has contributed to Canada's strong sense of identity and pride. The initial introduction of universal, public hospital insurance occurred in 1947 in Saskatchewan (Johnson & Stuart, 2009). That introduction set the stage and standard for all Canadian provinces and territories to eventually introduce a universal system of healthcare. By 1961, all Canadian provinces and territories had public insurance plans that gave their residents free access to hospital services, and by 1972 access was eventually extended to include physician services as well (Johnson & Stuart, 2009). By 1985, the government had passed the Canada Health Act, which brought into being what we now know as Canada's healthcare system (Madore, 2005).

Although the Canadian system is effective in ensuring that universal care is available to all residents, it does not ensure a time frame for the delivery of that care. Born and Laupacis describe access to care within Canada as consistently substandard and inferior, especially in comparison to other countries currently employing a two-tier system (2012). This poor ranking is made clear in a Commonwealth Fund report conducted in 2012, which compared Canada's healthcare system to the systems of thirteen other countries (Born & Laupacis, 2012). The report found that 51 per cent of Canadians felt the system needs a foundational change, while 10 per cent felt the system needs complete restructuring. Canada was reported as having the longest wait times for both

elective surgeries and specialist appointments and was rated second worst for after-hours access to care. In a comparison of wait times, the report noted that 41 per cent of Canadians had to wait two months or more for a specialist appointment, while only 5 per cent of Swiss and 7 per cent of Germans had to wait the same length of time (Born & Laupacis, 2012). Long wait times have been an ongoing issue within the current Canadian healthcare system. This is largely due to the fact that unlike many other countries, Canada does not offer patients the option of paying privately in order to avoid wait times and receive more immediate care.

Due to the long wait times they experience, many Canadians have begun to investigate alternative methods to gain access to the care they require. The main method being pursued, and one which has begun to grow in popularity and practice, is medical tourism. Medical tourism involves Canadians travelling outside of Canada to receive care that they pay for out-of-pocket. Canadian medical tourists regularly travel to a variety of countries around the world, such as the United States, New Zealand, the United Kingdom, and Mexico to receive care without waiting (Johnston, Crooks, Adams, Snyder, & Kingsbury, 2011). In 2011, Johnston et al. conducted a study that found the highest number of Canadians engaging in the act of medical tourism were between the ages of 40 and 65 years, although the overall range was from 18 months to 82 years of age. There was an equal number of men and women from a range of socioeconomic backgrounds involved in this practice. The second most popular reason cited for Canadians to seek medical care abroad was to avoid wait times. Medical tourism is not practised by one specific age, gender, or social group but is prevalent among a wide range of Canadian citizens, suggesting that a majority of Canadians feel that they face barriers to medical care in Canada (Johnston et al., 2011).

Although all Canadians have access to universal healthcare, they are still forced to investigate alternative options to avoid long wait times and receive immediate care. A purely publicly funded healthcare system, one with no real alternative to pay privately for medically necessary procedures, has caused many Canadian residents to feel insecure and uncared for within the current model and feel it necessary to travel to foreign countries to receive care. That practice then causes safety and medical concerns within Canada, as patient care is being conducted abroad and Canadian physicians have little to no control over care quality. The biggest concerns that the Public Health Agency of Canada have noted in regards to the practice of medical tourism are the standards of infection prevention and cleanliness in remote countries, the strain on doctor-patient relationships, and the follow-up care required once an individual returns to Canada (Johnston et al., 2011).

Introducing a two-tier healthcare system would help to diminish the practice of medical tourism and provide Canadians an alternative with respect to how and when they receive care. As noted earlier, Canada's system can be thought of as one-tiered. This single tier caters to the public at large and constitutes universal healthcare. A second tier, if introduced, would represent an alternative or secondary way for patients to receive care. It would allow patients to pay for their care on their own and, by doing so, avoid long wait times and gain better access to medically necessary treatment (Madore, 2005). This secondary tier would not replace what Canada currently has, but it would instead run parallel to it. In a 2010 CBC News article, Calgary Health Economist Herb Emery notes that Canada is in desperate need of a two-tier system. Emery explains how the current one-tier model prohibits people from accessing healthcare privately, should they so choose, and in doing so it harms their well-being and restricts a basic human right. Emery also describes how the financial pressure on the public system will only continue

This paragraph concludes with a summative statement that both underscores what the cited research has shown with respect to wait times and looks ahead to the next paragraph's focus on Canadians pursuing the option of "medical tourism."

Again, this is a clear and effective topic sentence that announces to the reader the central focus of this paragraph.

Here, the writer interprets data from a secondary source in a way that sets up the next part of her argument, extending the specific example of medical tourism into something symptomatic of a much larger problem.

The topic sentence directly relates this portion of the discussion as well as the previous two paragraphs concerning medical tourism back to the essay's central claim regarding the palpable benefits of two-tiered healthcare.

This statement introduces the portion of the argument that defends the writer's assertion that one of the benefits of a two-tier model is that it still allows for universal access.

While the writer takes a subtle approach to dealing with an opposing position, this portion of her argument does at least in part address one oft-cited argument against adopting some sort of two-tiered model: that it undermines entirely the concept of universal healthcare, a concept in many ways central to Canadian identity.

...and as the population of elderly people is estimated to grow by 25 per cent in 2030, while public funding is estimated to grow by only 1 per cent per year (2010). With these statistics in mind, the current system is simply not sustainable and a new viable option is needed to lighten the burden on the public system while simultaneously opening up more care options to Canadian residents.

Kheiriddin corroborates Emery's stance on the issue through a study tour she conducted in Sweden with respect to its two-tier healthcare system (2012). Her findings and observations were nothing but positive, noting increased innovation, decreased wait times, and equality of access for every Swedish resident. In Sweden, 3.7 per cent of the gross domestic product is spent on medical research and development, while in Canada only 2 per cent is allocated to the same (Kheiriddin, 2012). Canada has very limited flexibility to allocate extra funds to areas such as medical research and development, and this financial limitation leads to little advancement in the areas of healthcare innovation. In comparison, Sweden's healthcare system continues to thrive and grow largely because it is subsidized by both the private and public healthcare sectors.

The beauty of a two-tier healthcare system lies in how it preserves the foundational elements on which Canada's system was originally built: universality and equality. Implementing such a system does not close any doors but, instead, opens additional ones by providing alternative options for care. The essence of a two-tier system is that it provides a patient with choice. Allowing Canadian residents the option to choose how and when they receive care gives them more control and allows them to feel more empowered and responsible for their own health. Being forced to wait for a medically necessary procedure can make someone feel helpless. Allowing people to pay privately for procedures lifts some financial pressure off of the public system and levels the playing field with respect to care options, while simultaneously benefiting the economy as well as the overall quality of life for Canadians as a whole.

The topic sentence(s) of the conclusion—the summary statement—provide a reiteration of the writer's thesis without restating the thesis in the same terms. Like the report conclusion above, the conclusion here is wholly summative.

The writer makes a subtle emotional appeal to the reader here (an appeal to pathos) by invoking the common experience of feeling helpless. Such a gesture would be out of place in a report, but it can be usefully employed in an essay, since the goal is to persuade.

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CHAPTER SUMMARY

By this point, you should be able to:

- Assess the rhetorical situation of a document by considering its subject, audience, purpose, and limitations. You should also be able to define prewriting, distinguish

between simple and multiple audiences, and be able to employ the first person effectively and correctly in your academic writing.

- Distinguish generally between some common genres of academic writing, namely article reviews or critical analyses, reports, and scholarly essays, in terms of both form and content (as it is determined by the function of each document type). You should also understand the smaller differences between reports based on primary research and those based on secondary research, and you should be able to define the acronym IMRaD.
- Understand the purpose of and strategies for critical reading as that term applies to academic writing.
- Distill a topic from an assigned subject, then compose a specific and significant thesis statement that makes an assertion about your topic that you will be able to support by way of research.

Some self-check or class discussion exercises you might want to try include the following:

- Find an article dealing with a healthcare-related topic from a contemporary online media source (newspaper or magazine, blog, website) and approach that article as if you were preparing a critical analysis of it. Begin with ordinary reading, then go back over the article as a critical reader, using the “Strategies for Critical Reading” table as a guide. Ask yourself the questions there, and record your answers; be sure as well to follow through on the suggested tasks. In particular, identify and paraphrase the article’s thesis, then follow it with a point-form summary of the content.
- Take as your subject any ongoing healthcare conversation or debate in the media or one of particular personal interest to you. From that subject, try narrowing down to a possible topic on which you could write an essay or report. Do an internet search for your topic and find out what is being written about it; you may need to alter or refine the parameters of your topic (and thus your search terms) as you go. From there, try to brainstorm some possible thesis statements, then choose one (or more) and think about how an essay defending that thesis might be structured in terms of main points, organization, perhaps important objections/opposing points of view to include. Try doing the same thing in the context of a report. How might your draft thesis be rendered as a statement of purpose? How might an expository treatment of your topic proceed? What headings might a report on that topic employ to mark the organization and progression of the content?
- Find a piece of academic writing, your own or something published. Analyze it in terms of structure and organization by breaking it down into its component parts: What or where is the thesis/statement of purpose? Is there a summative conclusion? What sort of organization schemes are employed overall, as well as within individual paragraphs? What transitions and logical markers are used, and how do they help us to read and interpret the content?

Healthcare Research and Academic Writing

(Part 2):

Finding and Using Sources

8

This chapter focuses on the strategies involved in gathering and integrating information in order to write the sort of research-oriented academic documents explored in [chapter 7](#). The wider-ranging preliminary investigation into a subject that occurs during the prewriting stage and helps you to narrow down from that subject to a topic, then from topic to thesis (or statement of purpose) gives way as the drafting stage progresses to a more concentrated and detailed engagement with source materials, one that both shapes and is shaped by the developing focus and direction of your essay or report. Over the course of the research process, student writers may find themselves having to seek out answers to many important questions. Where do I look for sources, and how do I search for them effectively? How do I know if the sources I find are useful (or scholarly)? How do I get the information I want to use out of those sources and into my essay or report? What is appropriate documentation, and how (or why) am I supposed to do it? The goal of this chapter is to offer something by way of an answer to most, if not all of these.

FINDING SOURCES

Among the first things to consider as you undertake research for a particular assignment is what type of sources you are required to use. Is there an assigned limit with respect to number or type? If not, how many should you be aiming to employ in your paper and of what sort? First, consider the important contextual details of purpose and audience. Since you are writing something either to persuade a well-educated, expert reader (i.e., your instructor) or to inform that reader about your topic, the sources you marshal to the task of helping you address your audience most effectively need to be relevant, authoritative, and scholarly. A **scholarly source** refers to any research-based book, journal article, or essay written by someone with academic qualifications and affiliation, published by a reputable or university-associated press or in an academic journal, and searchable by way of your university or college library's system of databases. Journal articles tend to take slight precedence over books with respect to perceived importance and quality, primarily due to the fact that journal articles represent the most current published research in a field, and currency is an especially desirable characteristic for a source in the health sciences (and the sciences generally).

Scholarly sources can be categorized as either primary or secondary. A **primary source** is a first-hand account of something: an experiment, a course of research, an ongoing study. Lab reports and research articles constitute primary sources, as do dissertations and conference papers, published or otherwise. A **secondary source** consists of anything that draws upon, analyzes, and interprets primary material but doesn't write up research of its own. Literature reviews, critical analysis essays, reference works (e.g., dictionaries and encyclopedias), and textbooks like this one are examples. One possible strategy for moving from a general subject to a more specific topic during the prewriting stage is to focus initially on secondary sources only,

seeking out things like review articles, which summarize the prevailing thinking on and discussion of a subject and therefore allow you to find out about some of the topics scholars have addressed. Once you have settled on one or two such possible topics for your own paper, shift your focus to primary sources that document research on those topics, and see what's out there that engages and interests you the most (Hofmann, 2013). Note that the essay or report that you end up producing (by way of this method or any other) will most likely draw upon and cite both primary and secondary sources. However, some instructors may limit you to using one type or the other in a given assignment, most often primary.

Sometimes, assignment instructions might specify that you are to use only **peer-reviewed** sources in your paper. And indeed, being peer-reviewed is an important characteristic of the best, often most authoritative scholarly writing. As the condition of its publication, a peer-reviewed source has been rigorously vetted for quality by a group of experts in the subject area. It has been deemed credible and authoritative enough to make a contribution to the ongoing scholarly conversation and (potentially) to be used by other researchers as a source in the future. The peer-review process is a standard part of academic publishing, and it is a way of signalling to other academic readers that a book or essay or journal article has sufficient scholarly merit. Note that most databases now allow you to focus your search on peer-reviewed sources only. And if you are in doubt as to whether or not a book or a journal is peer-reviewed, read its publication details or a description of its editorial practice, either by following the link to that book or journal in your library's catalogue (as in the screenshot below), or by going directly to the publisher's website.

Publication Type:	Academic Journal
Subjects:	Nursing Administration & Management
Description:	Dedicated to issues relating to the management of nurses and nursing. Topics include clinical management methods, budget and resource allocation in health care, quality assurance, business and strategic planning, health policy etc.
Publisher URL:	http://www.wiley.com.proxy1.lib.uwo.ca/WileyCDA/
Frequency:	8
Peer Reviewed:	Yes

Screenshot: Publication details for *Journal of Nursing Management* (Academic Search Complete, Western Libraries).

Searching in Databases

In terms of seeking out scholarly source material, the best places to go are the discipline-specific subscription databases available through your university or college library. For healthcare-related disciplines, some of the notable ones are AMED, CINAHL, Medline, ProQuest Nursing and Allied Health Source, PsycINFO, PubMed, and SCOPUS. A more widely available, general scholarly search tool such as Google Scholar is also a fine place to start, as is Academic Search Complete. Even a non-healthcare specific database like the MLA International Bibliography might prove useful, for some topics related to narrative medicine and healthcare communication in particular. Regardless of where you start or what search tools you employ, to find sources effectively you need to be able to recast your topic as a set of searchable terms that you can then alter and adjust as need arises—need usually being determined by the number and quality (or lack thereof) of the sources your search yields.

As an example, let's imagine that you are asked to write a report on living with Parkinson's disease. You decide in trying to narrow down to a possible topic that you want to look at some of the treatment options available to Parkinson's patients, then go from there. What are the main concepts that inform your topic? How might those become workable search terms?

Look for nouns and noun phrases, and ignore function words (prepositions and conjunctions) and even verbs:

Treatment options for Parkinson's patients. [Main concepts = Treatment options, Parkinson's (since "patients" seems redundant, considering the focus on treatment, something that is necessarily patient-oriented)]

One strategy is to search each concept separately, then combine the searches. Here, however, since "treatment options" is imprecise and applicable to any sort of disease or ailment, you can anticipate getting an unmanageable number of sources, and that is an unproductive and discouraging way to start. Thus, search both of these terms together, using "AND" to link them. Note that you will have to put "treatment options" in quotation marks to ensure it gets searched as a phrase. Using the database PubMed to start, the combination of "treatment options" and "Parkinson's" gets you 284 sources.

PubMed

Create RSS Create alert Advanced

Summary ▾ 20 per page ▾ Sort by Most Recent ▾ Send to: ▾

Results: 1 to 20 of 284

<< First < Prev Page 1 of 15 Next > Last >>

This is a fairly unmanageable number of sources to skim through, even just by looking at titles and reading abstracts where necessary. You might notice some common terms recurring in the titles and descriptions of the sources you turn up, and those can help you narrow your focus a little more, hopefully leading to at least slightly fewer results. One of the recurrent terms in this search pertaining to Parkinson's treatment options is "brain stimulation." What happens when that gets turned into a concept added to our search string?

PubMed

Create RSS Create alert Advanced

Summary ▾ 20 per page ▾ Sort by Most Recent ▾ Send to: ▾

See 1 citation found by title matching your search:

Deep brain stimulation shows promise for Alzheimer's, depression treatment. Doctors also now have more options in how DBS is used to treat Parkinson's disease. et al. Duke Med Health News. (2010)

Results: 1 to 20 of 40

<< First < Prev Page 1 of 2 Next > Last >>

All of a sudden, you have reduced the number of sources considerably (from 284 to 40). There is no reason that you can't look at all 40 here in some detail before making a decision about whether or not you will have enough useful research to proceed with this particular topic, or whether you will have to alter your search again to broaden it a bit, perhaps generalizing the specific surgical intervention "brain stimulation" into the more inclusive category "brain surgery," or perhaps adding a synonym: "Parkinson's OR 'movement disorders.'" Going the other

way, if you want to focus things even more, you could make the third term “deep brain stimulation,” and/or you could apply some limits on source date and type (e.g., only within the last five years, only peer-reviewed articles).

Strategies for Skimming Journal Articles

In order to find and gather information as efficiently as you can during the course of your research, you need to be able to assess quickly and accurately which sources are going to warrant closer attention. To do that, you have to know what information to look for in a journal article and where to find it. Since the abstract provides a brief summary of the article’s contents, start there, then skip down to the very end and see what the discussion and/or conclusion section says regarding key findings and their significance. If the article seems like it might be helpful to you, then go back and start at the beginning, reading the introduction and seizing on the research questions or hypothesis that defines the purpose of the study before making your final decision as to usefulness.

EVALUATING YOUR SOURCES

Regarding the amount of source material you end up employing in the course of putting together your essay or report, it matters much less than how useful and credible that source material is. And it is, in fact, possible to employ too many sources in a paper, especially when it is short. You definitely need to produce a document that comes across as very well informed and that looks like it is conforming to the basic expectations of scholarly writing—namely, that it will incorporate and appropriately cite published research. That said, you do not want to hand in something that reads wholly like a pastiche of other people’s words and ideas, with little or no evidence of any distillation, framing, or analysis of those words/ideas on your part. Thinking generally about differences between exposition and argument, per our discussion of those modes in the [previous chapter](#), a report—being a more information-based type of writing and one less outwardly indicative of your own ideas or opinions—may be likely to have a higher number and concentration of source citations than an essay. But that is certainly not always going to be the case. In the end, there is no particular amount of source material to have in mind when you are getting your research together. You need as many sources as you need to do whatever it is your essay or report is trying to do, however unhelpful that may sound. Quality always takes precedence over quantity.

But how do you assess the quality of a source? While not all peer-reviewed sources are going to be equally useful to you, in terms of overall authority and trustworthiness, there is usually little to question about a scholarly book or article. The problem tends to be with non-scholarly sources, particularly those you find online. And note that when we say online, we are referring to the “open” internet accessible to anyone, not to the “closed,” subscription-only databases that students are able to access through their campus libraries. It is a retrograde approach to think that student writers in particular will limit their research to academic databases alone or that only scholarly sources can be of use in academic writing. Though scholarly books and articles should certainly comprise the majority of the material upon which you draw in essays and reports, some well-chosen non-scholarly sources—newspaper or magazine articles, websites, blogs, wikis, social media postings—can have much to offer by way of usefully supplementing your research material. Go back to the sample scholarly essay in [chapter 7](#), and look at the way some of the ongoing conversation about healthcare wait times in Canadian media sources (e.g., the *National Post* and *CBC News*) is used to frame the argument regarding the benefits of adopting a two-tier system. Particularly if your topic is a timely, relevant one that has been subject to

discussion in the media, sometimes the most up-to-date information you can get will come from online sources.

Be sure, however, to think very critically about whether or not such sources have intrinsic value that recommends their inclusion in your paper—whether or not they seem to offer you something useful that your scholarly sources don't. If an online source doesn't provide anything new or salient with respect to information or offer an approach that might enhance your discussion, then you should not bother with it. But if and when you do consider using a source you find via Google (or Bing or another search engine), there are several questions you then need to pose in order to evaluate its potential merit:

- Who or what is responsible for or behind the source? Is the site sponsored by an organization? Is it affiliated with an institution? If there is any corporate or institutional affiliation, what can you find out about the sponsor? Might there be some sort of political or professional bias inflecting the information or skewing its presentation? Are you being “sold” something, literally or figuratively? Is the site trying to get you to act or to buy something by relying heavily on appeals to pathos, perhaps presenting an especially rosy or particularly dire picture of things? Assuming there is a lack of objectivity as a function of the site's personal, political, or professional investment in a topic, does that pose a problem? Remember that much of your ethos as an academic writer derives from the quality and authority of your sources, and in academic writing authority and objectivity are very closely related.
- Who is the author? Is there one? What are his or her credentials? What is his or her ethos? Figuring out who wrote a scholarly book or article is never an issue, but figuring out the same with respect to an internet source can often be quite difficult. Not having an identified author isn't necessarily a deal breaker, but you need to think very carefully about the source's credibility on other grounds.
- What is the nature and quality of the information presented? Are citations provided? Frequently, they won't be, which can make accuracy difficult to discern. Importantly, though, does the information have intrinsic merit? Does it present information not available elsewhere and/or does it present that information in a way that other (scholarly) sources can't or don't? Is it multimedia dependent, for example? That's one of the important, potentially productive ways an online source might differ from a print source. The other, as we have noted, is in terms of currency. Is the source more up-to-date than anything else you've come across? Remember that the very thing that can make the information in an online source so useful—its potential timeliness—also speaks to one of the most problematic things about online sources in terms of authority, namely that they are inherently unstable and prone to alteration in ways that print sources are not.

One other thing to note: before evaluating any online source, try to parse the URL back to the homepage first, in the same way you would want to assess a book in its entirety by starting back at the beginning—with the author note, blurb, table of contents, introduction—not just picking it up *in medias res* (in the middle of things). You need to get the full picture of any source at issue in order to assess it fairly and in a fully informed manner.

USING SOURCES: AVOIDING PLAGIARISM

What does it mean to plagiarize, and why is it so important to understand what is at stake in plagiarism, with a view to avoiding it at all costs in your academic writing? **Plagiarism** is academic dishonesty that entails taking credit for someone else's intellectual property, whether intentionally or not. Determining just what constitutes the intellectual property of another,

however, can sometimes be tricky. The useful definition of plagiarism provided by the American Psychological Association (APA) publication manual—perhaps the most authoritative source on correct procedures for academic writing, particularly for those in healthcare fields—acknowledges the occasionally murky nature of intellectual property ownership in a passage that cautions against presenting

the work of another as if it were [your] own work. This can extend to ideas as well as written words. If authors model a study after one done by someone else, the originating author should be given credit. If the rationale for a study was suggested in the Discussion section of someone else's article, the person should be given credit. Given the free exchange of ideas, which is very important to the health of intellectual discourse, authors may not know where an idea for a study originated. If authors do know, however, they should acknowledge the source; this includes personal communications. (2010, p. 16)

Essentially, the intellectual property of others encompasses any words, ideas, and even inspiration you draw from things you have read (or people you have spoken to) in the course of preparing to write a document. In order to avoid plagiarism, you are required to acknowledge any and all of the sources you draw upon by citing your debt to them appropriately within your essay or report, using a standard **citation style** (such as APA), and also providing full bibliographic details in a list of references.

The practice of citing sources throughout your researched writing is referred to as **documentation**. When in doubt as to whether or not you should cite a particular source, the very fact that you are at least thinking on some level that you need to should be reason enough to cite it. Though overciting is possible (since sources of material considered standard information within a particular field of study—major historical facts such as dates, or facts readily available in a wide variety of reference works—need not be acknowledged), it is by far the lesser of two evils when the other option is unintentional plagiarism. So be vigilant about citing anything you think you need to. Following good academic procedure is never wrong, nor is being a fair person who gives credit where it is due.

Most colleges and universities use some sort of plagiarism-checking program, such as Turnitin, and these have made the detection of problems with integrating and documenting sources virtually effortless. In our experience, the majority of student writers who have any sort of issue with source acknowledgement or incorporation do not knowingly take credit for someone else's work with malicious intent. Instead, they usually plagiarize unintentionally due to one (or both) of two possible issues: they lack sufficient familiarity with their research material or knowledge of how to incorporate research into their writing; they have been too careless in taking notes from their sources (by failing, perhaps, to distinguish between direct quotations and their own paraphrase, or by not copying down correct page numbers). Students can help to prevent carelessness that results from haste by planning ahead and giving themselves sufficient time for the prewriting processes of rhetorical situation assessment and information gathering. Problems that arise out of a lack of knowledge or of comfort with using sources, however, can really only be addressed by learning the correct techniques for incorporating and acknowledging your research and by practising those techniques. To recall the preamble to our overview of grammar, punctuation, and style in **chapter 6**, practice makes permanent when it comes to the fundamentals of clear, effective writing. The same can be said for the basics of effective source citation and documentation.

Summary

Information drawn from research sources can be integrated into your essay or report in only three ways. You can summarize it, paraphrase it, or quote it directly. In all instances, the information

being drawn from elsewhere must be documented via in-text citation (and corresponding bibliographic entry). A **summary** distills key ideas from a source and condenses material presented at much greater length in the original into perhaps a paragraph or less in your paper, depending of course on the length and complexity of the original material being summarized. In the [previous chapter](#), we discussed summary in a couple of different contexts: in an article review, as the means of providing the necessary context for your critical analysis; and in the literature review portion of a formal report, which offers an overview of the relevant contemporary and historical research published on your topic. There are two other particular academic writing contexts wherein effective summary is absolutely essential: abstracts and annotated bibliographies.

Abstracts precede scholarly research articles in all disciplines, and they are a standard component in most types of report. As we mentioned earlier in this chapter, abstracts provide an important heuristic for readers, since they offer a brief but accurate summary of an article or report's contents in a single paragraph (approximately 300 words or fewer in the case of research articles, 150 or fewer for most lab reports). One of the keys to writing an effective abstract is to save it for the very end, after your article or report has been completed. That way, writing the abstract will truly be a summative, backward-looking exercise. You will presumably have arrived at a better sense of what it is you actually accomplish in your article or report and/or in the course of the research it discusses. There is actually quite a lot riding on a being able to write a clear, effective abstract, since readers will very often determine whether or not your work is interesting or worth reading solely on the basis of the abstract.

In an **annotated bibliography**, full bibliographic information for sources is accompanied by brief descriptions (usually three to five sentences at most) that summarize the content and offer some sort of evaluative commentary that speaks to the relevance and overall quality of the source (including its potential limitations or shortcomings). Here are a couple of examples of annotated bibliography entries for sources used in the sample scholarly essay with which our [previous chapter](#) concludes.

Flood, C. M., & Haugan, A. (2010). Is Canada odd? A comparison of European and Canadian approaches to choice and regulation of the public/private divide in health care. *Health Economics, Policy and Law*, 5, 319–41. doi: 10.1017/S1744133110000046

Flood and Haugan investigate the ongoing debate over allowing a privatized healthcare option into the Canadian system by way of the famous Chaoulli case from 2005, which asked if it was constitutional for the Quebec government to ban private insurance for medically necessary care in the face of long wait times. Flood and Haugan describe the shortcomings of and failures within this case, such as what steps were neglected and what was overlooked. They utilize six major features of Canadian healthcare legislation and use this information to draw comparisons between five European countries. **The Chaoulli case is a strong case study to utilize within my research because*** it brought healthcare issues to the forefront of national discussions and debates and highlighted the inefficiencies and inadequacies within the Canadian healthcare system. Although this case took place in Quebec under the Quebec Health Insurance Act, its information is still very applicable to Canada as a whole. The comparative analysis between countries provides insight on how Canada's system can be improved and where shortcomings lie. Although this comparison is generally useful, not all of the conclusions made by the authors are applicable to the Canadian system due to cultural, structural, and political differences between countries.

*Some annotations may demonstrate a reflective aspect in offering some sense of how or why a particular source fits into the writer's essay or report.

Johnson, A. P., & Stuart, H. (2009). Health services research in Canada. In R. Mullner (Ed.), *Encyclopedia of health services research*. (pp. 559–65). Thousand Oaks: SAGE Publications.

Johnson and Stuart begin their essay by providing a brief historical overview of Canada's healthcare system and its main goals and objectives, focusing on the idea of health information as well as health service research within Canada. This focus is important as it gives a substantial background as to why and how policies and infrastructures have been implemented within Canada, and explores the continuous developments research institutes and governments have been making in order to stay informed and make decisions based on qualified and substantiated research. This is a useful source because it provides an informative history of the Canadian healthcare system. It also describes how and why research is so important and the effects it has on policy makers, which in turn influences how health care is provided to citizens. While this article does not specifically focus on the two-tiered healthcare model within Canada, it still offers research that suggests how such a model might affect the delivery of care.

Annotated bibliographies may be assigned to take the place of literature review components or to provide a snapshot of your research in progress as you begin to move from prewriting to the drafting stage. In the latter case, the annotation can provide helpful notes that allow you to remember what you thought about a source in relation to your particular piece of writing (as in the first example above). Regardless of their specifics, all annotated bibliographies are impelled by the same important concern a literature review has of demonstrating some broad knowledge of what has been published on your topic and helping you to situate the place of your essay or report within an ongoing scholarly discussion.

To write an effective summary of any sort, you need to be very familiar with the source you are using. Read it over thoroughly, then (in a process akin to critical reading) go back over it slowly—or over the particular portion of the document you want to summarize—taking time to identify the key ideas by underlining or highlighting them. After that, try articulating the relevant points in brief, wholly in your own words. And when you have done that to your satisfaction, try combining those rewritten points together in a more condensed and concise manner. Go back and check your draft summary against the original to ensure both that you have covered all the ideas and that you have done so in language and syntax different from the source.

Paraphrase

In **paraphrasing**, you follow more closely the author's presentation of material (in terms of length and detail) than you do when summarizing, but you still cast things in your own words. While summary is useful for providing your reader with a broad-strokes overview of a source, paraphrase is better for a closer engagement with, or more focused use of, your primary or secondary research materials. If you want to present an author's argument or an aspect of her position in a manner and at a length more akin to the original, but you don't deem the original's words striking or interesting enough to be worth quoting directly, then paraphrase. As with summary, though, when you paraphrase, it is not enough that your version differs from the original at the level of diction; you need to strive for structural (grammatical and syntactical) difference too in order to avoid plagiarism. Also like summary, any paraphrase you include must be cited accordingly, with author's name and source date. Note that APA style does not demand that you include a page number in your citations of summary or paraphrase, even though a paraphrase in particular will necessarily seize on a portion of the original that is found on a specific page or couple of pages, something that won't necessarily be the case with summary. Still, according to the APA manual, when making reference to a point of content from another work by way of paraphrase, "you are encouraged"—but not required—"to provide a page or paragraph number especially when it would help an interested reader locate the relevant passage in a long or complex work" (p. 171).

Because paraphrase entails something more like a one-to-one relationship with your source in terms of length, you need to be wary of the strong potential to produce a version of a passage that is not sufficiently distinct from the original in all ways. Remember that effective paraphrase

involves rewriting entirely: not merely changing words but reframing how ideas are conveyed with respect to grammar and syntax. The following example illustrates an attempt to paraphrase part of [chapter 3](#)'s description of the benefits of attentive listening that falls short by focusing too much on the particulars of diction and not doing enough to recast the original passage on a broader structural level.

Original passage:

"Many patients, even routine users of the healthcare system or those who have developed prolonged professional relationships with their physicians, home care nurses, therapists, dentists, or any type of healthcare provider, are not surprisingly often intimidated during interviews or assessment and may be reluctant to make self-disclosures. It is therefore imperative that practitioners take the time to critically absorb all dimensions of a patient's narrative, and allow the patient to self-edit with the understanding that the process is more confession than interrogation."

Ineffective paraphrase:

Lots of patients, even those who regularly seek medical care or who have fostered close relationships with their doctors, nurses, physiotherapists, or other sorts of healthcare practitioners over an extended period of time, are still wary of revealing personal information in the context of being assessed or examined. Healthcare professionals must thus be patient and vigilant about taking in all aspects of their patients' personal stories; they need to give patients the freedom to self-edit, due to what needs to be seen as the confessional nature of provider-patient interactions.

With perhaps the exception of the rather distinctive term *self-edit*, this paraphrase does a decent job of staying away from the language used in the original. Certain key words—*patients*, for example, or *practitioners*—necessarily have to be used, and it isn't even an issue that *assessment* in the original gets rendered as the participle *assessed*, and *confession* closely informs the paraphrase's *confessional nature*. The problem is that, on the whole, this attempt at paraphrase only consists of swapping out the original words with synonyms. No attempt at all is made to restructure or rewrite anything. Aside from the troubling fact that it reads in relation to the original as if it were composed by someone who had a thesaurus open next to him, the paraphrase here problematically reproduces a couple of structural elements quite characteristic of the original. Specifically, it retains the list of various practitioners in the first sentence, and it articulates the logical relationship between the sentences in the very same way the source does, merely swapping out one conjunctive adverb (*therefore*) for another (*thus*) that serves the same function. And, of course, it is also noteworthy that no attempt at documentation is made either.

How might a more effective paraphrase of the same passage look? Here is one possibility:

Healthcare practitioners must learn to listen carefully and thoughtfully to their patients' stories and, as a result of the often-intimidating nature of the clinical environment, be attuned to the importance of allowing patients to disclose personal details on their own terms (Arntfield & Johnston, 2016).

While a bit shorter than the original (which is fine), in recasting the source as one sentence instead of two, the paraphrase here makes it easier to ensure there is structural difference. The first sentence of the original, which makes the point about the negative effects the intimidating nature of provider-patient interviews can have, gets relegated to a prepositional phrase within the main clause, and in turn, the original's seeming focus on the patient (as the subject of the first sentence) is changed to a focus on the practitioner. All told, this paraphrase distinguishes itself

from its source in terms of both the language it uses to convey the main idea and the grammatical construction it employs. What's more, a correctly formatted parenthetical citation is included at the end, as it should be, to acknowledge the writer's debt to the original.

As with summary, in order to paraphrase effectively you need to have much more than a passing familiarity with your source material; indeed, you need to know it fully and well, with respect to its diction, syntax, and style as well as its relevant details of content. Some student writers feel that it is counterintuitive to think that the more they immerse themselves in the nuances of the source they want to incorporate into their essay or report, the less likely they will be to plagiarize it unknowingly. Often, the approach seems to be that keeping a more healthy distance from your sources will prevent any accidental overlap between the words or style of the original and your own. Nothing actually bears that out, however, and it is always better to get as familiar with your sources as you can, something you can really only do if you allow yourself sufficient time during the prewriting stage and after to gather, read, annotate, and revisit your research materials.

Direct Quotation

Quote directly from a source in moderation. That is, do it only when the exact words of the original seem especially important or telling; when the author says something more succinctly, elegantly, and interestingly than you ever could; when you want to employ the words of an authority to lend support to your points; and/or when the original passage warrants closer analysis in your essay or report. Outside these scenarios, your default setting as an academic writer should be to paraphrase or summarize. Obviously, any and all words taken directly from a source need to be set off in quotation marks, and a citation that includes a page number needs to be provided. A quotation may be introduced into your writing by way of a **signal phrase**, which is a reference in the body of your paper to the source of the quoted material that follows. When a signal phrase is employed, the parenthetical source citation in APA style need only include the page number, since name and date have already been given.

According to Bonk (2015), "beginning writers should understand that mechanics are just another set of tools for writers to use when conveying information to audiences" (p. 101).

Signal phrases can also be used to introduce summary or paraphrase, and they can be particularly useful rhetorically if the material you want to introduce comes from a noted authority whose name is recognizable to the reader. Effective academic writers will always strive for variety in how their incorporated sources get introduced throughout, however, employing signal phrases only sometimes.

In terms of mechanics, there are a few things worth pausing over when it comes to quotations. First, any quotation you include needs to blend seamlessly into your writing. While we know that the main clause-colon-quotation construction is a perfectly acceptable way to introduce and incorporate quoted material, stylistically it is the least sophisticated and most mechanical. When you integrate a quotation into your prose effectively, you should be able to read aloud the sentence of which it is part without being able to discern by ear (possible presence of a signal phrase aside) where the quoted author's words begin and where your own words end.

It goes without saying that "Among the key steps that healthcare writers must take is citing sources for information used within documents" (Bonk, 2015, p. 68).

Bonk's suggestion that acknowledging one's debt to source materials "not only displays respect for others' work but also can protect writers from lawsuits regarding copyright infringement" (p. 68) usefully frames documentation as both a moral and legal imperative.

As both of these examples demonstrate, well-integrated quotations should not compromise the grammatical integrity of your writing. And note that, unlike the citations for paraphrase or summary, which occur right before the nearest punctuation mark after the paraphrased/summarized source material, citations for direct quotations go immediately after the end of the quote in APA style.

Quoted material may be modified slightly, so long as its meaning is not affected. Use an ellipsis (...) to indicate where something has been omitted in order to condense the quotation. What remains still needs to work grammatically. Remember that any material omitted from a quotation must be unnecessary to your reader's understanding of what that quotation is attempting to say or accomplish, and it cannot be essential to the tone or intent of the original.

As Hofmann (2013) describes, "Reading and understanding ... research papers is mainly a matter of experience and knowledge of the specific vocabulary of a field" (p. 146).

The original quotation refers to "Reading and understanding primary articles or research papers," but the writer here has decided to omit the first term to address the specific needs of her paper: "primary articles" is not used elsewhere in her document, and the quotation is being employed in a passage that addresses research papers specifically. Since the original links "primary articles" and "research papers" together with the coordinating conjunction "or," the suggestion is that they are interchangeable terms; the same things are required to read either of them effectively. As such, omitting the first term does nothing to alter the original's meaning or intent, but it renders the quotation more usefully focused and concise while still maintaining grammatical integrity.

To add something to a quotation, employ square brackets ([]). As with material omitted when quoting a source, added material cannot change or distort the original meaning. You should alter quotations by way of addition only sparingly, ensuring that each time you do it is either to provide necessary context, to explain a confusing or unclear reference, or to make a sentence work better grammatically with your own writing (by, for example, changing tense for consistency).

Bonk (2015) notes how one "typical [organizational] strategy for simple situations is chronology: describing how a process occurs in time" (p. 44).

In this example, what the writer deems to be an important detail of context and clarification is added. The original quotation from *Writing for Today's Healthcare Audiences* comes from a chapter dealing with ways of organizing information in healthcare documents, but the writer uses the quotation in a way that doesn't necessarily make that context as apparent as it might, so he introduces the modifier "organizational" to ensure the reader knows just what sort of strategy is being referred to. He is erring on the side of caution here, since precision and clarity should always be what guide a writer's decisions. The addition of a single clarifying word adds little to the original quotation in terms of length and does nothing to undermine sentence grammar or alter meaning.

Lastly, when a quotation is long—40 words or more in APA style—it cannot be integrated into the body of your text and must instead be offset or blocked. When quotations are offset, they must begin on a new line, indented from the left margin the distance of a normal paragraph indent (approximately half an inch). Contrary to what many student writers seem to think, each line of the offset quotation will extend to the right margin, then start again on the next line at the same half-inch distance from the left as the previous. The text of such quotations should be in the same font and of the same size as the text elsewhere in your paper, and uniform double-spacing must be maintained. It is also the case that offset quotations need not be enclosed in quotation marks, since the block formatting itself provides a sufficient visual signal to the reader that the material is being taken directly from a source. Obviously, a parenthetical citation is still required

at the end, but the punctuation will occur before that citation, not after. Writers should strive to avoid quoting at length, if possible, as too many block quotations—even one or two in a short paper—can affect ethos adversely by making the writer look lazy.

DOCUMENTING SOURCES: APA STYLE

APA (American Psychological Association) style, the documentation style employed by and referred to throughout this book, is used in most health and social science disciplines. Like the other primary North American documentation style—that of the Modern Language Association (MLA), which is employed in arts and humanities disciplines such as English—APA style employs in-text parenthetical citations that are keyed to an alphabetized list of bibliographic entries, called “References” in APA, “Works Cited” in MLA. The expectations a documentation style has regarding the form and content of citations can tell us about what aspects of a research source a particular discipline values most and wants to emphasize. APA citations always include the date of publication in addition to the author’s name, and the suggestion therein is that disciplines using this style put emphasis on both the source and the currency of the information: who or where it comes from and how contemporary and thus (in theory) how relevant it is. Certainly, in healthcare-related fields, providing the most recent research you can is key. Focusing where possible on sources that fall within a three-year window from the present is a good place to start. Many university and college writers will have access to citation management software—such as EndNote, Mendeley, RefWorks, or Zotero—that will compile in-text citations and bibliographic entries for their research sources according to whatever style they are using. Such programs are not infallible, however, and errors of formatting and organization do occur. Students need always to review any auto-generated documentation very carefully.

We have discussed already in this chapter, and provided examples that illustrate, some differences between summary/paraphrase and quotation with respect to citation form and location. It is not our intent to provide a comprehensive discussion and analysis of APA style, in all of its detail and frequent complexity. When asking any questions regarding specific points of formatting, citation mechanics, or “References” list construction, writers should always first go directly to the source by consulting the *APA Publication Manual* in addition to the APA’s very useful website (www.apastyle.org), where the most up to date information about and ongoing discussions of APA style can be found. What follows here is meant to provide only a very brief rundown focused on some of the more common points of confusion or misunderstanding with respect to in-text citations, bibliographic entries, and document format. For each topic, relevant section numbers from the sixth edition of the APA manual are provided to facilitate more detailed review and discussion.

1. APA In-text Citations

To review the basic formats of in-text citations, go back over the examples in our sections on paraphrase and direct quotation. See also “Table 6.1: Basic Citation Styles” in the APA manual (6th edition).

		RELEVANT SECTION IN APA MANUAL
PROBLEM	SOLUTION	

Source has no author	Cite using shortened version of the title (since the title will be in the author position for the References entry), followed by date.	7.02
Source has more than two authors	Three to five authors: cite all the names the first time, subsequent to that just the first author and "et al." (Latin et alia: and others). Use first author's name and "et al." for every citation if there are six or more authors.	6.12
More than one source from the same author	Year of publication should distinguish between sources, but if all are from the same year, use lower case letters in addition to date (e.g., 2012a, 2012b, ...).	6.16
Source has a corporate author	Cite using name of corporation (or association, agency, etc.) plus date.	6.13
Source has no date	Use "n.d." instead of date.	6.28
Source has no page numbers	Use what you can. If there are paragraph numbers, use those (preceded by "para."). If there are section headings, use the titles or shortened titles of those. Also, remember that you really only have to provide page numbers when you are quoting.	6.05
Source is personal communication	Use communicator's name, followed by "personal communication," then the date as exactly as possible (e.g., June 29, 2015).	6.20

Source is social media	If paraphrase or quotation is of material readers can't access (due to privacy settings or because it was a PM), cite as personal communication above. If content is publicly accessible, then cite author and date, per usual.	6.20, 6.31, APA website's style blog (http://blog.apastyle.org/apastyle/2013/10/how-to-cite-social-media-in-apa-style.html)
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2. APA References Entries

Below are some sample References page entries to model, covering the basic sorts of print and online sources you are likely to encounter in the course of your research. Remember that whatever appears in the author position of a reference entry must also be what appears as part of the corresponding in-text citation, whether as a signal phrase or as the first portion of a full parenthetical citation. As well, all sources cited in-text must have a References entry (and vice versa).

Fierlbeck, K. (2011). *Health care in Canada: a citizen's guide to policy and politics*. Toronto: University of Toronto Press. [Book]

Flood, C. M., & Haugan, A. (2010). Is Canada odd? A comparison of European and Canadian approaches to choice and regulation of the public/private divide in health care. *Health Economics, Policy and Law*, 5, 319–41. doi: 10.1017/S1744133110000046 [Journal article with Digital Object Identifier (doi)]

Johnson, A. P., & Stuart, H. (2009). Health services research in Canada. In R. Mullner (Ed.), *Encyclopedia of health services research*. (pp. 559–65). Thousand Oaks: SAGE Publications. [Chapter in an edited book/entry in a reference work]

Kheiriddin, T. (2012, June 28). Think two-tier health care would be a disaster? Ask a Swede. *National Post*. Retrieved from <http://www.nationalpost.com/index.html> [Online newspaper article]

PROBLEM	SOLUTION	RELEVANT SECTION
Source has no author	Use the title of the work in the author position, alphabetized by the first letter (excluding <i>the</i> , <i>a/an</i>).	7.02
Source has multiple authors	Include every author's name in entry (last name, initial) up to seven; after the sixth author, use an ellipsis (...) followed by the last author's name.	7.01

More than one source from the same author

Single author entries by the same author are listed chronologically, earliest publication date first. Where publication dates are the same, alphabetize by title of work and put a letter (a, b, c) after the year to correspond with how those works will be cited in-text (see above). Multiple author entries in which the same author is listed first are alphabetized according to last name of the second author.

6.25

Source has no date

Use "n.d." in parenthesis instead of date.

6.28

Source is an e-book

Enter as you would a print book with "Retrieved from" and URL taking the place of the publishing information. Retrieval statement is replaced by doi, where applicable.

7.02

Source is personal communication

Not applicable: cite in-text only.

6.20

Source is a movie or a TV show	For a movie, follow book entry format, with producer's and director's name in author position, each with their function in parentheses: (Producer). Title of the movie goes in italics, studio takes the place of publishing house. For TV shows, follow the entry format for a book chapter (above), but put the scriptwriter and director in the author position, and the producer in the editor position, labelling each function as in a movie entry. Title of the episode takes the place of the essay title, and the title of show itself is italicized, like the book title. Broadcasting corporation takes the place of publishing house.	7.07
Source is social media	If cited as personal communication, no References entry is required. If not cited as personal communication, however, entry must provide author, date, title, and URL. If both real and screen names are known, provide screen name in square brackets; if only screen name is known, use it without brackets. For title, provide the page name or post caption, followed by content format in square brackets (e.g., [tweet]).	6.20, 6.31, APA website's style blog (http://blog.apastyle.org/apastyle/2013/10/how-to-cite-social-media-in-apa-style.html)

Quotation marks vs. italics	Use quotation marks only for citing the titles of short works—essays, articles, chapters—in the body of your paper. In the list of references, those titles go in a regular font face, with no quotation marks. Italics are used for titles of longer works (e.g., books, journals, magazines, newspapers), both in-text and in your references.	4.21, 6.15
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3. APA Document Format

For an example of APA formatting specifics in practice, see the sample student paper below.

COMPONENT EXPECTATION		RELEVANT SECTION
Running head	Use abbreviated version of title, maximum 50 characters, all uppercase; locate in upper left corner on all pages (including title page).	8.03 (and Fig. 2.1)
Title page	Include title, running head (per above), author name, author note, institution, page number (1).	8.03 (and Fig. 2.1)
References list	Uniformly double-space, make each entry hanging (or reverse) indented.	2.11
Page numbers	Locate in upper right corner, use Arabic numerals (i.e., 1, 2, ...).	8.03 (and Fig. 2.1)
Line spacing	Uniformly double-space throughout, even block quotations.	8.03

Example: APA Formatted Student Report (Title page, first page, References)

Preceded by "Running Head" only on title page; only the capitalized version of the title thereafter. Full report title is used for running head since it is fewer than 50 total characters.

Embryonic Stem Cell Therapy for Type-1 Diabetes

Alexa Buxton
Western University

EMBRYONIC STEM CELL THERAPY FOR TYPE-1 DIABETES

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12-point Times New Roman font. Title should be centred, mid-way down the page.

Embryonic Stem Cell Therapy for Type-1 Diabetes

Diabetes mellitus is a chronic disease that affects approximately 346 million people worldwide (World Health Organization, 2014). There are multiple types of diabetes, but the focus of this report will be type-1, or insulin-dependent diabetes. Type-1 diabetes is most often caused by an autoimmune attack by the body in which the insulin-producing cells of the pancreas called beta cells are destroyed. The destruction of these cells creates an insulin deficiency that results in high blood glucose levels, and these high glucose levels in turn damage blood vessels and consequently lead to serious medical complications. Because of their insulin deficiency, type-1 diabetics must receive synthetic insulin through subcutaneous injection or pump (Franz, 2008). Although synthetic insulin is certainly beneficial, it is not equivalent to that which is naturally secreted by the pancreas. Normal functioning beta cells produce the exact amount of insulin necessary to balance the blood glucose levels; however, synthetic insulin is administered by the patient him- or herself and, therefore, will never be as accurate in dosage (Slack, 2014). To date, there is no cure for type-1 diabetes. As this report explores, however, there have been several advancements in the field of embryonic stem cells including recent groundbreaking research from the Harvard Stem Cell Institute that may promise a cure in the near future.

Title is repeated on the first page, centred, double spaced above first line of text.

1-inch margins all around. Note too that all text is left ragged (unjustified) on the right, which facilitates ease of reading.

Historically, the main focus of diabetes research has been on islet transplantation—a procedure that involves the transplantation of beta cells taken from the pancreases of deceased

No additional space is required between paragraphs. Even if headings are used, the text should remain uniformly double-spaced.

EMBRYONIC STEM CELL THERAPY FOR TYPE-1 DIABETES

7

References

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Format for citing an ebook with a doi.

Journal article with more than seven authors.

Format for citing a blog post.

CHAPTER SUMMARY

By this point, you should be able to:

- Distinguish between primary and secondary sources, as well as between scholarly and non-scholarly sources. Additionally, you should be able to assess online sources for their relative quality and develop functional search terms out of a topic.

- Define plagiarism and understand what constitutes another's intellectual property. You should also understand what documentation is, what is at stake in summarizing and how to do it effectively.
- Recognize the difference between paraphrase and summary, as well as between effective and ineffective paraphrase. You should also be able to recognize what is at stake in quoting directly and why you would choose to quote rather than paraphrase. And you should be able to alter quotations correctly when needed in addition to knowing how and when to offset them.
- Create both appropriate APA style in-text citations and correctly formatted References page entries for a variety of source types. You should also be able to format an essay or report correctly according to APA expectations.

Some self-check or class discussion exercises you might want to try include the following:

- Choose a broad, healthcare-related subject that interests you, and develop from it a couple of different possible topics. Then, break each of those topics into concepts, develop search terms from those concepts, and plug those terms into an academic database. Compare the results of one topic's search to the other's, and think about which topic would be a more viable, productive one were you actually to write an essay or report. After that, choose a couple of other databases and repeat the same searches. Are your results the same? Play around with your search parameters in each database to familiarize yourself with the various search features available.
- Write three annotated bibliography entries from sources you found doing the previous exercise, or do so using sources you find online. Ensure that your entries are all formatted according to the expectations of APA style.
- Find an academic article that interests you—perhaps again using the search terms you created for the first exercise—and read it carefully. Then summarize it. After that, paraphrase a key portion, and then quote from that same portion. Try writing a sentence that includes a quotation and employs a signal phrase, then one without. Include proper in-text citations for each, as well as for your summary/paraphrase. Think about the differences in citation content, and consider the reasons for those differences.

Chapter 6 Review Quizzes

QUIZ 1: GRAMMAR

Word Classes, Verbals

Part A. In the sentences below, identify the **word class** (part of speech) of each underlined word. If a word is one thing in class and another in function (e.g., a pronoun that functions as an adjective), identify it according to its function in the sentence.

1. Today, Joan's teacher made an announcement about the upcoming field trip.
2. He said the test would be challenging, though he should have said it would be impossible.
3. Wow! Renee didn't stop crying until the end of the convocation ceremony.
4. Two kids are even better than one because each keeps the other occupied.
5. A dedicated and competent nurse is always expected to put duty above personal interest.
6. Being equally forgetful, both my roommate and I had left our keys in our apartment.

Part B. In the following sentences, underline any **verbals**, then label each verbal you identify according to its type. **Where no verbals are present in a sentence, leave the sentence untouched.**

1. My friend's wife certainly loves to shop for shoes whenever she can.
2. The angry tenants complained regularly but got no response from their aggravating landlord.
3. Jacob has lost thirteen pounds by dieting and taking vitamin supplements daily.
4. The big surprise to all of us is that our corrupt mayor was not convicted sooner.
5. Scared and badly mistreated, the puppy took a long time to warm up to the loving, gentle staff at the shelter.

QUIZ 2: GRAMMAR

Sentence Types; Phrases and Clauses

Part A. For each of the following sentences, identify the **sentence type**, then underline and label the **main and subordinate clauses**.

1. Working together, those three brave firefighters extinguished the blaze completely with their hose.

2. As usual, my neighbour Louis appears rather annoyed at having to go to work in the morning, so he backs out of the driveway quickly and without saying “hello.”
3. Until yesterday, Dr. Jorgensen had been away at a conference for university administrators.
4. Do not offer your poor girlfriend any more of that awful chicken recipe because you don't want her to get sick.
5. Though she had been dealing with the ravages of Parkinson's disease for years, his grandmother, who was the strongest woman he knew, still refused to give up her independence, and he loved her for that.

Part B. In each of the following sentences, please identify **the underlined word group** as a clause or a phrase. In the case of a clause, please also indicate whether it is main (independent) or subordinate (dependent).

1. The happiness of her mother meant everything to Joan.
2. Early Friday afternoon is the time we always start our party.
3. If a person takes little pride in his appearance, other people can always tell.
4. I complimented Julie when she finished the job, and she seemed rather pleased.
5. Many people believe that anyone can earn a university degree, but they are mistaken.
6. Being equally incompetent, both my lab partner and I submitted our lab reports two weeks late.
7. Deep tissue stimulation, a new, relatively inexpensive mode of treatment, is now used in physical therapy since it has been shown to help flexibility and promote healing.

QUIZ 3: PUNCTUATION

Commas, Semicolons, Colons, Dashes, Apostrophes

Part A. Edit the following sentences to correct any errors in the use of the comma, semicolon, colon, apostrophe, or dash. **Do not change any sentences that are already punctuated correctly.**

1. Canada's mens hockey team left Sochi with the ultimate prize; Olympic gold.
2. Whenever the young nurse felt especially nervous, she used deep breathing exercises to calm herself down.
3. Effective writing is not understood the same way by every student, it's elements can sometimes vary between disciplines.
4. Angela needed to find an article for her healthcare communication review assignment, however she could find only sources unrelated to her subject of Parkinson's treatments.
5. Those three family doctor's leases will be coming up for renewal next month.

6. That writing prof was nice enough to grant a later due date for Erica and Judy's group report.
7. My buddy Matt, who's dream it had always been to own a classic Camaro, searched the used car lot in vain.
8. I think that being a triage nurse would be fun, you get to meet so many interesting people all of the time.
9. Art, English, and geography; these are his sons favourite subjects.
10. Their infield consisted of the usual group; Steve, the free-swinging first baseman, Carts, the all-glove second baseman, Upton, the strong-armed shortstop, and Nick, the team's best all-around player and third baseman.
11. All of those students, who sat in on Dr. Jorgensen's most recent lecture, now want to take a neurobiology class.
12. My brother always sauntered into a room with a graceful breezy confidence.
13. The successful nursing student needs, desire, intelligence, strong work ethic, perseverance and good study habits.
14. Our basement office is being remodelled, therefore we have no carpet, furniture or lighting fixtures right now.
15. The APA manual recommends the following, "Cite the work of those individuals whose ideas, theories, or research have directly influenced your work."

QUIZ 4: COMMON GRAMMATICAL ERRORS

Sentence Boundary Errors, Agreement Problems

Part A. In the constructions below, repair any fragments either by attaching them to nearby sentences or by rewriting them. In the case of run-ons, revise using whatever technique you find most effective. **Do not change any sentence constructions that are already correct.**

1. To pass my MCATs with flying colours and get into med school. That is my ultimate goal.
2. The second-year nursing students' opinions on what constitutes effective research did not always correspond with the ideas of their instructor, thus, there was frequently anxiety when it came time to submit assignments.
3. Joan really needs help re-venting her dryer, be sure to give her a hand with it.
4. Poor Mr. Jones still feels caught between two distinct worlds. The world of his drinking buddies in his old neighbourhood and the world of his fellow dialysis patients at the hospital.
5. With Florence Nightingale Syndrome, White Coat Syndrome, Post-Hospital Syndrome, and others. It is hard enough to memorize all of the syndromes that land people in the hospital in the first place, let alone all of the conditions that the hospital itself produces.

6. The aging doctor's bedside manner has received mixed reviews from patients. Many find it rather abrupt.

Part B. In each of the following sentences, correct any problems of agreement. If sentences are already correct, do not change them.

1. The teachers' union lost their right to bargain.
2. The recently graduated nurse, along with several of his former classmates, strongly oppose many of the forthcoming changes to the nursing curriculum.
3. Each of the exam sections require 45 minutes to complete.
4. Just when I think I can leave the clinic, another pile of forms appear on my desk.
5. Almond butter and grape jelly are her daughter's favourite lunch.
6. Being carefully attuned to the patient's physical and psychological needs are imperative when he first arrives at our facility.
7. A patient with MRSA infection does not deserve to be subjected to exclusionary behaviour or callousness on the part of their healthcare providers.

QUIZ 5: COMMON STYLISTIC ERRORS

Faulty Parallelism, Passive Voice, Modifiers

Part A. Edit the following sentences to correct faulty parallelism. Do not change any constructions that are already parallel.

1. In the first two years of the nursing program, most classes focus on theory, and little emphasis at all is placed on practice.
2. Three reasons why that team keeps losing are that their players are inexperienced, inability to compete for free agents, and competition in their division is improving.
3. His doctor promised he would receive not only a clean bill of health but also an early discharge.
4. Dr. Ferguson, the new pediatrics resident, told us that he enjoys reading more than to watch television on his days off.
5. The orderly currently working the night shift in the ICU is neither punctual nor is nice to patients.

Part B. Edit the following sentences to make passive constructions active. If the active voice is already employed, do not edit.

1. Patients coming to our practice are advised on our website not to expect same day bookings.
2. In Dr. Smith's recent article, it was mentioned that some Parkinson's symptoms can be effectively managed with Botox.

3. In the case of measles, serious illness can be avoided by getting a simple, proven vaccination.
4. Your corrupt mayor is being ridiculous in demanding that taxpayers cover his legal expenses.
5. Only in the last few years has DBS been addressed in the literature as a viable treatment option for Parkinson's.

Part C. In the following sentences, correct any misplaced or dangling modifiers. **Do not change any constructions that have no modifier problems.**

1. Having completed assigned rounds, the stack of charts was then reviewed by Lisa, the new nurse on the floor.
2. After working a night shift in the ER in the wintertime, your car should be warmed up and ready to go, which is in part why a remote car starter might be a good investment for shift workers.
3. Dr. Jones only conducted AIDS research when he could get time away from his practice, something that seemed to be happening with less regularity in recent months.
4. After an initial triage and interview, leaving a patient quickly increases the likelihood of additional symptoms being overlooked.

Review Quiz Answers

QUIZ 1: WORD CLASSES, VERBALS

Part A.

1. Adv., Noun, Adj.
2. Pron., Vb., Conj., Vb., Adj.
3. Int., Prep., Adj.
4. Noun, Adv., Pron.
5. Conj., Adv., Prep.
6. Adj., Adj. (Pron.), Vb., Prep.

Part B.

1. to shop (infinitive)
2. aggravating (pres. participle)
3. dieting and taking (gerunds)
4. no verbals
5. scared, mistreated (past participles); loving (pres. participle)

QUIZ 2: SENTENCE TYPES: PHRASES AND CLAUSES

Part A.

1. Working together, those three brave firefighters extinguished the blaze completely
(MAIN)
with their hose. [Simple]
2. As usual, my neighbour Louis appears rather annoyed at having to go to work in the morning,
(MAIN)
so he backs out of the driveway quickly and without saying "hello." [Compound]
(MAIN)
3. Until yesterday, Dr. Jorgensen had been away at a conference for university administrators.
(MAIN)
[Simple]
4. Do not offer your poor girlfriend any more of that awful chicken recipe
(MAIN)
because you don't want her to get sick. [Complex]
(SUBORDINATE)

5. through she had been dealing with the ravages of Parkinson's disease for years,
(SUBORDINATE)
his grandmother, who was the strongest woman he knew,
(MAIN) (SUBORDINATE)
still refused to give up her independence,
(MAIN)
and he loved her for that. [Compound-complex]
(MAIN)

Part B.

1. Phrase
2. Phrase, main clause
3. Subordinate clause
4. Main clause
5. Subordinate clause
6. Phrase
7. Phrase, phrase

QUIZ 3: COMMAS, SEMICOLONS, COLONS, DASHES, APOSTROPHES

1. Canada's men's hockey team left Sochi with the ultimate prize: Olympic gold.
2. Whenever the young nurse felt especially nervous, she used deep breathing exercises to calm herself down. (correct)
3. Effective writing is not understood the same way by every student; its elements can sometimes vary between disciplines.
4. Angela needed to find an article for her healthcare communication review assignment; however, she could find only sources unrelated to her subject of Parkinson's treatments.
5. Those three family doctors' leases will be coming up for renewal next month.
6. That writing prof was nice enough to grant a later due date for Erica and Judy's group report. (correct)
7. My buddy Matt, whose dream it had always been to own a classic Camaro, searched the used car lot in vain.
8. I think that being a triage nurse would be fun; you get to meet so many interesting people all of the time.
9. Art, English, and geography—these are his son's favourite subjects.
10. Their infield consisted of the usual group: Steve, the free-swinging first baseman; Carts, the all-glove second baseman; Upton, the strong-armed shortstop; and Nick, the team's best all-around player and third baseman.
11. All of those students who sat in on Dr. Jorgensen's most recent lecture now want to take a neurobiology class.
12. My brother always sauntered into a room with a graceful, breezy confidence.

13. The successful nursing student needs desire, intelligence, strong work ethic, perseverance, and good study habits.
14. Our basement office is being remodelled; therefore, we have no carpet, furniture, or lighting fixtures right now.
15. The APA manual recommends the following: "Cite the work of those individuals whose ideas, theories, or research have directly influenced your work."

QUIZ 4: SENTENCE BOUNDARY ERRORS, AGREEMENT PROBLEMS

Part A.

1. To pass my MCATs with flying colours and get into med school is my ultimate goal.
2. The second-year nursing students' opinions on what constitutes effective research did not always correspond with the ideas of their instructor; thus, there was frequently anxiety when it came time to submit assignments.
3. Joan really needs help re-venting her dryer, so be sure to give her a hand with it.
4. Poor Mr. Jones still feels caught between two distinct worlds: the world of his drinking buddies in his old neighbourhood and the world of his fellow dialysis patients at the hospital.
5. With Florence Nightingale Syndrome, White Coat Syndrome, Post-Hospital Syndrome, and others, it is hard enough to memorize all of the syndromes that land people in the hospital in the first place, let alone all of the conditions that the hospital itself produces.
6. The aging doctor's bedside manner has received mixed reviews from patients. Many find it rather abrupt. (correct)

Part B.

1. The teachers' union lost its right to bargain.
2. The recently graduated nurse, along with several of his former classmates, strongly opposes many of the forthcoming changes to the nursing curriculum.
3. Each of the exam sections requires 45 minutes to complete.
4. Just when I think I can leave the clinic, another pile of forms appears on my desk.
5. Almond butter and grape jelly is her daughter's favourite lunch.
6. Being carefully attuned to the patient's physical and psychological needs is imperative when he first arrives at our facility.
7. A patient with MRSA infection does not deserve to be subjected to exclusionary behaviour or callousness on the part of his or her health care providers.

QUIZ 5: FAULTY PARALLELISM, PASSIVE VOICE, MODIFIERS

Part A.

1. In the first two years of the nursing program, most classes focus on theory and place little emphasis at all on practice.
2. Three reasons why that team keeps losing are inexperienced players, inability to compete for free agents, and improving competition in their division.
3. His doctor promised he would receive not only a clean bill of health but also an early discharge. (correct)
4. Dr. Ferguson, the new pediatrics resident, told us that he enjoys reading more than watching television on his days off.
5. The orderly currently working the night shift in the ICU is neither punctual nor nice to patients.

Part B.

1. Our website advises patients coming to our practice not to expect same day bookings.
2. Dr. Smith's recent article mentioned that some Parkinson's symptoms can be effectively managed with Botox.
3. In the case of measles, you can avoid serious illness by getting a simple, proven vaccination.
4. Your corrupt mayor is being ridiculous in demanding that taxpayers cover his legal expenses. (correct)
5. The literature has addressed DBS as a viable treatment option for Parkinson's only in the last few years.

Part C.

1. Having completed assigned rounds, Lisa, the new nurse on the floor, then reviewed the stack of charts.
2. After working a night shift in the ER in the wintertime, you should have your car warmed up and ready to go, which is in part why a remote car starter might be a good investment for shift workers.
3. Dr. Jones conducted AIDS research only when he could get time away from his practice, something that seemed to be happening with less regularity in recent months.
4. After an initial triage and interview, quickly leaving a patient increases the likelihood of additional symptoms being overlooked.

Glossary

Abstract: A standard component of reports and scholarly articles, an abstract summarizes the content of the academic document it precedes in a paragraph of usually no more (and frequently less than) 300 words. Abstracts are a very important component of published scholarly writing in the sciences in particular, since readers often use abstracts as the primary means of determining whether or not to read an article.

Acronym: Any existing or invented word where each letter is a substitute for another word, and where the resulting abbreviation is read like a word itself (FEMA, SARS, NASA, FANBOYS). See also: **Initialisms**.

Adjectives: Descriptive words that modify nouns by answering the questions “which one?” or “what kind?” Definite and indefinite articles (i.e., *the* or *a/an*) fall under this word class. See also: **Article**.

Adverb: A class of word that modifies verbs, adjectives, and other adverbs. Adverbs provide information that answers a variety of questions: How? How often? When? Why? To what extent?

Analogue: Here, used to refer to a document, record, or other physical media that exists in a fixed, hardcopy format.

Annotated bibliography: An alphabetized list of research sources in which full bibliographic entries are followed by brief descriptions that summarize the content and offer evaluative commentary that speaks to the relevance and overall quality of the source, sometimes including potential limitations or shortcomings.

Annotation: Describes any additional entries, remarks, comments, notes, or afterthoughts that accompany a main piece of writing, such as handwritten remarks inserted into a printed copy of an electronic medical record (EMR).

Antecedent: The noun for which a pronoun stands in and to which that pronoun refers.

Anthology: A collection or assemblage of writings, usually by various authors. In healthcare, this would include all the writings that comprise a patient record or some other file that has numerous contributors.

Appositive: A word or group of words that follows a noun in a sentence and provides modifying information by renaming, identifying, explaining, or describing that noun.

Argumentation: The structured process by which, in writing, a concept, idea, or course of action is rationalized, supported, and reasoned.

Article: A subcategory of adjective, articles are either definite (*the*) or indefinite (*a/an*). Because they invariably precede nouns, they are sometimes referred to as noun markers (or determiners).

Aspect: Describes the quality of a verb that indicates whether or not the action named has been completed or is ongoing. Aspect is indicated through the combination of past or present participial forms and auxiliary forms of *to have* or *to be*.

Asynchronous writing: A writing style that is generally representative of most cybermedical prose and which describes the nature of the internet itself, in that transcripts of what often look like immediate (synchronous) exchanges actually don't occur in immediate succession in most cases. Just as asynchronous learning describes the way distance-based courses are taught online, asynchronous writing describes electronic prose that is written at one time and then read and responded to sometimes days, weeks, or even months and years later.

Attentive listening: A key component of narrative medicine, it describes a competency of oral healthcare communication whereby a practitioner not only listens to the words being uttered, but also assesses factors in non-verbal communication, including being mindful of his own body language and facial expressions in order to elicit as candid a discourse from the patient as possible.

Blogosphere: A term generally referring to the network of weblogs (blogs) that co-exist on the internet at any given time, with many being linked either directly or indirectly, and being part of a larger culture of writing and information exchange among bloggers as an identifiable group of electronic writers subscribing to a dominant prose style.

Case: The form a pronoun takes to denote its grammatical function in a sentence. There are three case forms: subjective (used when the pronoun is in the subject position), objective (when the pronoun is functioning as an object), and possessive (when the pronoun takes the form of a modifier indicating ownership). Unlike pronouns, nouns do not change their form according to case, though they do require the use of an apostrophe (or apostrophe -s) to mark possession.

Channel: The means by which a message is transmitted, channels can be written or oral, print or electronic, formal or informal.

Charting: The process of writing or otherwise contributing to a patient record, including the expository overview and summarization of precise actions, observations, methods of care, and other relevant details. See also: **Parallel charting**.

Citation style: The method used to index primary or secondary sources for the purposes of both in-text citations and when populating a bibliography at the end of a written work. Common citation styles include APA, MLA, and Chicago (CMS), although some publishers use some variation of one or more of these, known as a "house style" particular to a single publishing house. Not to be confused with **Reference format**. See also: **Documentation**.

Clause: A group of words containing both a subject and a verb. Clauses can be divided into two categories: main or independent (which can stand on their own as sentences) and subordinate or dependent (which cannot).

Climactic organization: A form of organization in which content is ordered not in accordance with some sort of linear logic (e.g., chronological, spatial, hierarchical) determined by the nature of the content itself but rather as a function of the writer's decision regarding what order works best to achieve a particular rhetorical purpose, usually persuasion. Climactic organization is

indicative of an externally imposed organizational scheme. See also: **Exact organizational scheme**.

Clinical progress record: Also known by similar names (clinical progress notes, etc.), this is the designated narrative text space on a standardized healthcare form, and is typically associated with handwritten notes made in primary and secondary care-delivery environments. See also: **Flowsheet**.

Common law: A system of law in the United States and Canada (except Quebec) and inherited from Britain, whereby a number of rules and regulations are in place that have no official statutory or legislative origin, and have become accepted procedures by way of custom or tradition and continuously reinforced by official court decisions.

Comparative literature: A vast area of multidisciplinary research and scholarship that compares the literature, texts, and media of two or more identifiable languages or cultures, including a critical examination of how texts evolve over time and influence each other.

Complete subject: The noun that names who or what a clause is about, plus any words that modify that noun. See also: **Simple subject**.

Concision: A strategic approach to expository writing and editing in which no more words than are necessary to adequately describe something are used, and in which sentences are arranged with specific clause structures to allow for this.

Conditions of rebuttal: Points of weakness in an argument that allow for objection and/or invite refutation. Effective writers should draft their arguments always with a view to identifying possible conditions of rebuttal as they occur and finding ways to deal pre-emptively with the objections that may be used to undermine the argument at such points. See also: **Refutation**.

Conjunctions: Linking words that can be divided into two categories: coordinating conjunctions (*for, and, nor, but, or, yet, so*), which link sentence elements that are grammatically or conceptually equal (e.g., phrases to phrases); and subordinating conjunctions, which link subordinate clauses to main clauses. Correlative conjunctions are common two-part linking constructions in which the second part always consists of or includes a coordinating conjunction (e.g., *either ... or, not only ... but also*).

Counterargument: A strategy for dealing with an opposing position (or some aspect of it) that entails acknowledging that position, then reasserting the strength and validity of your own argument (or some aspect of it) to show how it warrants consideration still. Counterargument is one strategy for rebuttal; refutation is the other. See also: **Refutation**.

Critical reading: A multi-stage, focused, and goal-oriented approach to reading a text with a view to being able to understand and analyze the various ways in which that text works to achieve its purpose (or to fall short of achieving it). Critical reading entails a deeper awareness of both textual and contextual considerations, and it incorporates elements of the reader's response to and experience of the text. Especially in the context of literary or non-academic texts, it can be synonymous with close reading. See also: **Ordinary reading**.

Custodian of records: A person or group of persons who are charged with administering, maintaining, and preserving the continuity of an institution's records, including all official

written materials, as well as financial and personnel records.

Cyberchondria: A neologism derived from “hypochondria,” it is intended to describe unfounded or irrational concerns about having or acquiring an illness, or inaccurately self-diagnosing, based on excessive reading of online materials, often of unsourced or dubious origin.

Description: One of the four main rhetorical modes and common to the writing of pathographies, it involves writing that is primarily descriptive, anecdotal, and seeks to visually represent or recreate a person, place, or thing.

Didactic narrative: Any text, usually fictional or semifictional, that is covertly instructional in nature and serves to teach readers or viewers something through the use of story, typically some type of logical or moral lesson.

Digital humanities: A growing area of scholarship, teaching, and research that focuses on the way computing and electronic records management practices impact and influence traditional humanities disciplines, including but not limited to literature, art, linguistics, and history. See also: **Medical humanities**.

Digital object identifier (doi): Alphanumeric tag that provides a stable, persistent means of identifying and locating electronic documents. Where available, a doi should always be included in the bibliographic entry for a source found online.

Direct object: Noun or pronoun that names a person or thing directly affected by the action of the verb. Verbs that take direct objects are referred to as transitive; those that don’t are called intransitive.

Documentation: In academic writing, the process of acknowledging one’s sources correctly by means of employing both in-text citations and corresponding bibliographic entries. A documentation (or citation) style, such as APA style, provides a set of rules governing documentation procedures and the form and content of source citations. See also: **Plagiarism**.

Dyadic communication: Communication—written and/or oral—involving two people.

Electronic medical record (EMR): Sometimes referred to as an electronic health record (EHR), it describes the collection, or anthology, of documents that comprise the official record of a patient’s healthcare history, but which are housed in a purely electronic format to allow for timely sharing and access across different clinical delivery environments.

Empathic writing: A term associated with parallel charting and portfolio writing that describes the ability to write with empathy and document facts and observations while being sensitive to the experiences of the person or persons being described.

Entry: Commonly used in reference to handwritten notes or records, it describes any notation or combination of letters, numbers, or characters that are made in relation to patient care, in respect of a patient record, or otherwise made as part of a healthcare professional’s duties.

Ethos: One of the three principles of rhetoric, it refers to the character, credibility, or authenticity of a piece of writing and can be cultivated through, amongst other things, effective and accurate sourcing.

Exact organizational scheme: A means of organizing document content according to the linear internal logic of that content, whether chronological, spatial, hierarchical, etc. Exact organizational schemes play to a reader's expectation as to how a particular experience should be described or how a particular subject should be discussed, considering its nature. These are internally determined ways to order content, as opposed to the author-determined, externally opposed model of climactic organization.

Exposition: One of the four main rhetorical modes and the one most emblematic of healthcare writing, it involves effective summarizing, explaining, and informing.

Expository prose: The result of applying exposition to the institutional writing process, and the effective and expressive use of technical and professional language to convey ideas or document occurrences.

Flow of information: In professional (workplace) communication, this refers to the direction within an organizational hierarchy that an act of communication moves. Upward communication goes from subordinates to superiors; downward goes from superiors to subordinates; and horizontal occurs between peers and/or employees at the same level.

Flowsheet: A standardized collection of forms that contain textual, graphic, and numerical data with respect to a patient, and that collectively form part of a patient record. See also: **Clinical progress record**.

Forensic: Derived from the Latin *forensis* (public forum), it refers to any process, including writing, that can or will ultimately be subject to public disclosure through any number of legal processes, and which may in turn be subject to legal scrutiny and those executing the process (including writers) subject to being examined or deposed on public record.

Freedom of information: A blanket term that refers to any number of laws or policies that allow for public requests for access to otherwise internal and/or unpublished records held by an institution.

Gatekeeper: Reader with the power to prevent a message from getting through to the intended, primary audience. See also: **Initial audience**.

Grammatical case: Sometimes referred to as letter case, this is a general term referring to the typographic or handwritten structure of letter characters in a text, and is generally divisible into title case, sentence case, and block lettering, or all capital letters.

Grand rounds: Also known as the chief's grand rounds or chief resident's grand rounds, a training curriculum found in teaching hospitals where various symposia and workshops are held for all clinical staff, and where items of general or common interest across various areas of healthcare specialization are discussed.

Grey literature: A term that refers to a body of written work, including official reports or proposals, whose authorship and origin is often difficult to track for continuity and citation purposes, thereby placing it in a "grey area" in terms of date submitted, primary authors, and other pieces of information normally required in any piece of literature that is released publicly.

Health 2.0: A recently coined term that describes the newest applications of cybermedicine in the context of online health promotion; specifically, the second version (or version 2.0) of cybermedicine, in which asynchronous writing for social media platforms by clinicians and other healthcare practitioners and scholars is becoming increasingly recognized and legitimized.

Highly qualified personnel: An increasingly common term used to describe professionals with completed university level educations (bachelor's degrees and above) and who are seen as vital to the current knowledge-based economy and future intellectual growth of a given nation or region.

Holophrasis: The practice of using a single word to convey a larger idea that transcends multiple word classes or that stands in for a whole sentence.

Hybrid documents: Samples of text that exist largely in electronic forums, including blogs and wikis, that contain elements of both expository/institutional writing and descriptive/narrative-based writing, and that are intended for both professional and general audiences.

Impact factor: The most common measurable used to determine the relevance, readership, and credibility of a scientific or scholarly journal. The practice of measuring impact factors began in 1975 and is largely determined by how frequently written work in one journal shows up in the form of secondary source citations in other journals.

Indirect object: Noun or pronoun naming a person or thing to or for whom the action of the verb is accomplished—someone or something involved in/affected by the action secondarily. Indirect objects will not appear in constructions that don't have direct objects, and they can almost always be thought of as being aware of their involvement in the action, a fact that helps to distinguish them from objects of the prepositions *to* or *for*, which, unlike indirect objects, will identify where (as opposed to whom/what).

Initial audience: The first reader(s) to see a document, the initial audience may offer suggestions for revision or refinement. Sometimes, initial audience and gatekeeper are the same, in which case the initial audience has the ability to prevent a document from going to its intended (primary) audience.

Initialisms: Abbreviations spelled out using the first letter or letters of the words being conjoined, usually in block letters. Unlike an acronym, where the abbreviation forms a new or existing word, an initialism is supposed to be spelled out one letter at a time (CDC, WHO, FBI). See also: **Acronym**.

Institutional writing: Any form of writing carried out in relation to or in respect of duties affiliated with an institution (hospital, courthouse, jail, school), and therefore the property of the institution rather than the author.

Intellectual property: Originally a legal concept that has since come to have broader applications, it refers to any piece of writing or other media, and even non-material items, that amounts to ideas or concepts of the mind that are the exclusive domain of the creator or person who conceived them.

Interjections: Words that denote an exclamation of strong feeling (such as *Oh!* or *Hey!*). Interjections are the only one of the eight word classes to be grammatically independent of the sentences they precede or interrupt. They are frequently punctuated with exclamation points.

Interpersonal communication: Communication that takes place, either in person or through written media, between people or small groups with some knowledge of each other and usually with some sort of shared experience or desire for a common goal.

Intertextuality: Describes the manner in which the sharing of texts mutually influences the content of each independent text through a narrative interrelationship.

Jargon: Specialized technical terms associated with a particular professional, educational, or disciplinary background. While the appropriate use of jargon can show expertise and authority to readers familiar with such terminology, jargon can be impenetrable and off-putting to non-specialist readers.

Keywords: Any limited set of words that are selected for use in indexing healthcare journal articles, as well as ensuing search engine optimization for medical blogs, and that are generally representative of the material covered in any piece of writing, typically for empathizing or illustrating a central theme.

Knowledge-based economy: A term that describes the current post-industrial economic system and job market, where services take priority over commodities, and where tasks are increasingly specialized in nature, requiring an increasingly specific and often elusive combination of education, training, and experience among highly qualified personnel.

Leak: A term that can be used as either a noun or a verb to describe the unauthorized or ill-timed release of documentary information or publication of—usually sensitive or copyrighted—material through unofficial channels or methods of distribution.

Logos: One of the three principles of rhetoric, it refers to the ability to cultivate logic, reasonableness, and rationality in a piece of writing.

Medical humanities: A term describing the interdisciplinary shift in healthcare education toward the adopting of texts, learning models, and research methodologies used in humanities disciplines, such as narrative and discourse analysis, comparative literature, and hermeneutics. See also: **Digital humanities**.

Metacommentary: The rhetorical strategy by which writers effectively comment on their own writing and signal to their readers how they want a statement/idea to be understood, particularly in relation to some other idea. Metacommentary can be as simple and subtle as employing logical markers (such as conjunctive adverbs like *however* or *therefore*; prepositional phrases like *for example*; or adverbs like *finally* or *similarly*) to map a particular relationship of ideas within a document. It can also take the form of more pointed statements of signposting and/or summary, such as “What researcher A is suggesting in his article is ...” or “Having established ___, I now want to shift focus a bit by ...”

Mnemonic: A learning strategy for use in memorizing concepts. Often used to refer to the technique of using a word, frequently an acronym, to serve as a reminder for the key items in a list, with each letter in the word serving as a reminder for each step in an ordered procedure. See also: **Acronym**.

Multidisciplinary: An adjective that describes the convergence of multiple academic, scientific, or professional disciplines under one umbrella, and using that convergence to maximize the field

of vision or objective perspectives through which an issue can be examined or studied.

Multiple audience: An audience of readers who are not like-minded and who do not have the same level of knowledge or set of expectations with respect to your subject matter. The real or imagined discrepancies between members of a multiple audience can be a function of gender, demographics, and/or of differing sociocultural, educational, professional, or experiential backgrounds. See also: **Simple audience**.

Narration: One of the four main rhetorical modes and a common literary technique in narrative medicine and parallel charting, this involves storytelling using either chronological or thematic sequencing.

Narrative medicine: A broad and intricate concept (and practice) that links patient care with narrative structure, with practitioners understanding illnesses as stories told from the perspective of patients, and also recognizing—and often writing about—the patient–clinician encounter as its own story. See also: **Parallel charting**, **Portfolio**.

Neologism: A new and emerging but generally recognized term that is created in response to a specific social, cultural, or technological trend, and which may or may not have entered common everyday language or official dictionaries and encyclopedias.

Nomenclature: Accepted or regularly used terms, phrases, or symbols that are common to a specific field or discipline, and that form part of the language system of the community working in or amongst such a field or discipline.

Noun: A word that names a person, place, or thing (conceptually) and acts as either a subject or object (grammatically).

Ordinary reading: Distinct from the structured, slower, more goal-oriented process of critical reading, this term describes the (often initial) experience of reading a text in an uninterrupted manner and at a normal pace. As the first step in writing a critical analysis, ordinary reading is sometimes referred to as previewing.

Parallel charting: A process distilled from narrative medicine, this involves maintaining secondary logs, journals, or unofficial patient records that can serve as cathartic outlets for personal written reflection among healthcare practitioners, the goal being to improve holistic patient care. See also: **Portfolio**.

Parallelism: A rhetorical device in which sentences are constructed with two or more clauses or phrases written in a similar way so that when superimposed or read in succession, they serve to make a point more clearly and emphatically. Parallelism is a scheme that employs similarity in form to underscore similarity in meaning.

Pathography: A written summary, study, or analysis—usually conducted in retrospect and by either a healthcare professional or a patient—detailing a person's or group of people's struggle with an illness, as well as the life course of the illness itself.

Pathos: One of the three principles of rhetoric, this refers to the ability of a piece of writing to awaken and elicit emotions or sentiments in a reader, and/or to appeal to a reader's beliefs and expectations.

Peer-reviewed: Describes a piece of academic writing that has been subjected to a process of editorial screening by expert readers as a condition of publication and, thus, deemed sufficiently credible and authoritative.

Phrase: A group of words missing either a subject or a verb or both. Phrases cannot stand on their own as sentences, but they can provide modifying information in a clause and can also act as nouns.

Phonoaesthetics: A phenomenon describing how words are chosen, popularized, or otherwise evolve to reflect collective preferences in sound and delivery. Moreover, it describes how certain words, their meanings, and their accompanying word sounds are deemed pleasant or unpleasant, and either offensive or innocuous based on socioeconomic and cultural factors.

Plagiarism: Misrepresenting the intellectual property of another as one's own, intentionally or otherwise. Plagiarism can be avoided in academic writing by summarizing or paraphrasing research sources correctly and by indicating all debts to source materials by way of appropriate **documentation**.

Pointing: A term used in medical blogging—and website hosting generally—that describes one or more domain names being “parked” (an active domain with inactive hosting) which then automatically redirects the user to the active “master” site where content is populated. An example would be acquiring the same domain name and URL with .com, .ca, and .net extensions, and then having the latter two set up to point back to the .com site as the default location for all web traffic.

Portfolio: A collection of representative written works that reflect improvement, evolving sophistication, and adaptability as a writer. In the specific content of healthcare—more specifically narrative medicine—portfolio describes the practice of healthcare practitioners and students authoring reflective pieces at varying intervals, doing so with the view that their narrative awareness and empathic skills can be evaluated over time. See also: **Parallel charting**.

Portmanteau: The practice of taking two or more words and combining them to make a new word for which an appropriate term does not yet exist. The new word contains not only a merged word sound but also preserves the original meanings of the words being merged.

Preposition: Linking word that connects a noun or pronoun (the object of the preposition) to another (often preceding) word or group of words in a clause. Prepositions and their objects together make phrases that provide modifying information.

Prewriting: The very first stage of the writing process, involving gathering preliminary information on your subject and assessing the rhetorical situation of your document. Prewriting precedes drafting. See also: **Rhetorical situation**.

Primary audience: The audience for whom a document is composed. The needs, knowledge, expectation, and characteristics of a primary audience must be assessed as part of the prewriting stage. See also: **Secondary audience**.

Primary source: Documents a first-hand account of research. Examples are lab reports, research articles, conference papers, dissertations, works of literature, historical documents such as letters or speeches. See also: **Secondary source**.

writing occurs as part of the **prewriting** phase.

Rhetorical triangle: A figurative geometric concept in which the three principles of rhetoric (ethos, logos, pathos) are configured as an equilateral triangle, suggesting that each principle should make an equal contribution in working toward a common point.

Secondary audience: Readers who encounter a document after the fact and/or who may be affected by the content of a document after it has been received and acted upon in some way by the primary audience.

Secondary source: Reports and analyses of information drawn from other sources. Examples include review articles, reference works, textbooks.

Sentence case: When all principal words in a title or sentence, other than the first word of the sentence and proper nouns, begin with lower-case characters. It is also used in library catalogues and scientific literature as the letter case used in referencing titles of original works.

Shorthand: Historically, a substitution-based symbol system used when taking dictation or handwriting lengthy documents quickly, but now generally describing any accepted system of using abbreviations or ciphers to save time and space when composing a written record.

Signal phrase: An in-text reference to the source of quoted, paraphrased, or summarized material that follows.

Signposting: A characteristic many thesis statements demonstrate when they anticipate the general organization of ideas in the body of the essay that follows. It is sometimes referred to as forecasting.

Simple audience: An audience of readers who are like-minded and who have the same level of knowledge or set of expectations with respect to your subject matter. The real or imagined similarities between members of a simple audience can be a function of gender, demographics, and/or of similar sociocultural, educational, professional, or experiential backgrounds.

Simple subject: The single-word noun, stripped of any modifiers, that names who or what a clause is about.

Statement of purpose: A clear and concise articulation of the writer's objective in an academic report, conventionally included at or near the end of the introduction. In an experiment-based report, the purpose statement will take the form of a hypothesis and/or set of research questions. See also: **Thesis Statement**.

Syntax: The grammatical arrangement of words within a sentence.

Tense: Refers to the quality of a verb that indicates the time of the action named—whether it occurred in the past, is occurring presently, or will occur in the future.

Thesis statement: Concise statement that articulates the central claim to be argued in an essay, usually occurring at or near the end of the introduction. See also: **Statement of purpose**.

Title case: A letter case distinction whereby all principal words in a title or brief sequence of words begin with a capital letter; it is found most frequently in commercially advertised titles, such as film, television, trade press books, and other media. In healthcare, its use reduces shorthand misinterpretation.

Unique visitors: The number of distinct, individual users visiting a website or requesting web page data from a server over a fixed interval of time (24 hours, 30 days, etc.) as determined by factors such as internet protocol (IP) address. Generally considered the most effective proxy for the relevance of a given website, regardless of the length of each unique visit.

Verb: Word that describes either an action carried out by the subject of a clause, or a state of being the subject experiences. The portion of a clause introduced by the verb is called the predicate. Verbs that name actions can be either transitive, which means they take a direct object, or intransitive, which means that they do not.

Verbals: Also known as non-finite verbs, verbals are verb forms that function as some other word class, either a modifier (adjective, adverb) or a noun. Verbals come in three forms: infinitives, past participles, and present participles. When present participles function as nouns, they are referred to as gerunds.

Verbatim: Meaning “word for word,” this describes the process of a word, series of words, or entire narrative being repeated or transcribed precisely as it appeared in the first instance or in its original form.

Wiki: A collaborative online writing endeavour that allows multiple approved authors to co-author and co-edit online narratives and databases that are categorized by specific topic.

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